

# Family Planning and Medicaid Managed Care Integration, Phase Two Report: Insights from the Field

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Sara Rosenbaum, JD  
Caitlin Murphy, MPA-PNP  
Rebecca Morris, MPA  
Peter Shin, PhD, MPH  
Jessica Sharac, PhD, MSc, MPH

In collaboration with Health Management Associates

Milken Institute School  
of Public Health

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THE GEORGE WASHINGTON UNIVERSITY

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# Executive Summary

For over 40 years, Medicaid’s “freedom of choice” guarantee has ensured that Medicaid beneficiaries enrolled in managed care can obtain family planning services from their Medicaid-participating provider of choice, regardless of their provider’s status as a member of their plan’s provider network. Yet, this unique protection has essentially gone unstudied for four decades.

In 2020, with the support of Arnold Ventures, Milken Institute School of Public Health researchers developed a two-part study whose purpose was to explore how the family planning freedom of choice guarantee has been implemented over the years, the current status of family planning as a managed care in-network benefit, and how the freedom of choice safeguard is integrated into managed care practice. Our phase one report<sup>1</sup> revealed that despite the existence of what might be considered a “carve-out” arrangement, in fact states, in implementing managed care through complex purchasing agreements, have incorporated family planning as a core managed care benefit. At the same time, however, the study found that contract terms remain under-developed and typically lack detail regarding the full scope of contractor obligations with respect to coverage, access, provider network composition, and member education about the freedom of choice guarantee.

Our phase two report explores the experiences of health plans and family planning providers under Medicaid managed care. Through 24 interviews with health plans and providers, we sought to understand in greater depth the relationship between managed care organizations, family planning providers, and the provision of family planning services, including challenges experienced by plans and

providers in establishing or joining family planning networks, issues with coverage and payment, the presence of efforts to apply value-based payment strategies to family planning, and experiences with member education around freedom of choice.

## Key Findings

- In-network status is the norm for both community health centers and family planning-only providers, with some exceptions. Health plans overwhelmingly prefer network inclusion for family planning providers in their service areas.
- The norm for providers is in-network patient care, although providers do see patients on an out-of-network basis, consistent with the freedom of choice guarantee.
- Member understanding of the freedom of choice guarantee is limited.
- Health plans by and large perceive family planning as a key element of primary care, although some prefer to view family planning as occupying its “own pillar,” that is, as a specialized care need in its own right.
- CMS’s longstanding distinction between family planning and family planning-related services has caused confusion and has increased the risk that patients will not be fully treated when they use out-of-network providers, in contravention of the freedom of choice guarantee.
- Value-based payment strategies in a family planning context appear to be at an early stage at best, although both plans and providers expressed eagerness to test payment reform.
- Both plans and providers report that access

to family planning remains a problem.

- Plans and providers quickly adapted to providing telehealth services during the COVID-19 pandemic, which helped to maintain access to care.
- Family planning providers generally report making all birth control methods available, but some problems are noted.
- Health risk screening and referrals for medical and social services present a significant activity for family planning providers, but providers reported variable ability to address social determinants of health (SDOH).

### **Key Policy Recommendations**

- 1) Although family planning provider networks appear to be the norm, **continued access to out-of-network care remains an extremely important guarantee**. As such, member education on the freedom of choice provision should be required and **billing guides** should clarify the services covered under this guarantee.
- 2) Despite the benefits of the freedom of choice safeguard, states, plans and providers all appear to **value and pursue family planning integration as a basic feature of Medicaid managed care**. Therefore, **states could encourage a robust approach to family planning provider integration** within plans' service areas **as a basic contracting expectation**.
- 3) Utilization management remains a matter of concern. For this reason, states could clarify the types of utilization management approaches that are considered permissible. **Plan contracts should include a clear prohibition against the use of prior authorization prior to obtaining family planning services from an out-of-network, Medicaid-qualified family planning**

provider, as allowed under federal law.

- 4) Given the support of plans and providers, states should consider **payment reforms that encourage innovation in the accessibility and quality of family planning services**, such as additional service sites and hours, programs targeted to certain high-risk populations, and enhanced follow-up care for certain high-risk patients.
- 5) The 2016 CMS policy of "family planning" versus "family planning-related" services remains an unforced error that has led to significant adverse consequences where access and quality is concerned. **The policy should be reversed and the family planning benefit definition should be modified to expand the full range of services identified in federal law.**

## Background and Overview

This report examines the experiences of Medicaid managed care organizations and family planning providers in the provision of family planning services. This report should be viewed as the second part of a major two-part, first-of-its-kind study into the evolution of family planning and Medicaid managed care. As such, this phase two report builds on our previous research<sup>2</sup> into how states integrate family planning into comprehensive Medicaid managed care arrangements.

Extensive research shows the role of family planning in promoting healthy pregnancy, birth, and the health of children, parents, and families.<sup>3</sup> In order to ensure that Medicaid beneficiaries would have access to this vital healthcare service, Congress mandated family planning as a Medicaid benefit in 1972, and the benefit has been mandatory for a half century.<sup>4</sup> Congress carried this family planning coverage mandate over into the Affordable Care Act (ACA), which extends family planning services to all newly eligible Medicaid beneficiaries under the ACA expansion, and which also amended the definition of Medicaid family planning itself to make the service even more comprehensive.<sup>5</sup>

When Congress added family planning as a benefit mandate, what we know today as Medicaid managed care – i.e., provision of Medicaid coverage through managed care organizations that administer state Medicaid plans and arrange for access to care through a network of participating providers – did not exist. In 1981, as part of comprehensive reforms that broaden states' options to mandate managed care as a condition of coverage, Congress also exempted family planning from the coverage and network restrictions that ultimately would come to apply under Medicaid managed care. Today, states have the option of incorporating family planning into their comprehensive agreements, but even if states do so, plan members can continue to obtain Medicaid-covered family planning services from

the qualified Medicaid provider of their choice, regardless of their provider's network status.<sup>6</sup> This direct access guarantee has been a basic feature of Medicaid managed care for over 40 years, and yet its impact on how states approach the question of family planning integration has never received close attention.

Our first phase of this two-part study found that despite Medicaid's longstanding "freedom of choice" guarantee, states have actively pursued a "carve-in" strategy for family planning, incorporating benefits into their contracts as a core feature. In doing so, states have embraced family planning as part of their "whole-person" approach to health care and uniformly include family planning as a core feature of their contracts. At the same time, however, the study found that states tend to draft the family planning provisions of their contracts in general terms and typically not to include details regarding the full scope of contractor obligations with respect to coverage, access, and provider network composition and capabilities. Contracts also tend to be silent regarding contractors' role in informing members about the freedom of choice guarantee, as well as acceptance of in-network referrals by out-of-network providers in the case of family planning patients who require physical and mental health follow-up care – a relatively common occurrence among family planning patients who depend on public clinics.<sup>7</sup> Furthermore, contracts only rarely addressed value-based payment for family planning or family planning-related performance measurement and quality improvement.

- whether family planning providers experience barriers to obtaining in-network status, getting paid for certain types of services, or effectuating referrals for follow-up care;
- whether plans experience challenges in enrolling family planning providers as network providers or whether family planning remain outside of plan networks given their right to be paid for covered services regardless of their network status;

- the types of coverage and payment issues that might commonly arise in the MCO/family planning provider relationship, such as issues that arise in connection with certain birth control methods; issues related to the diagnosis and treatment of STDs by out-of-network providers; HPV vaccination in family planning settings; or other preventive services related to reproductive health but not strictly family planning care;
- whether plans and providers perceive members as understanding their freedom of choice rights or instead, as looking only to their plans for the family planning and related services they need.

The answers to these questions can provide important insights for states regarding how best to structure their purchasing agreements to ensure optimal access and outcomes.

## How We Conducted This Study

The first phase of this study included interviews with Medicaid agencies from 10 case study states (AZ, CO, GA, IL, KS, KY, LA, MA, NJ, WA).<sup>8</sup> This report summarizes our findings from the second phase of this study, which consisted of 24 separate interviews of providers and health plans. Providers were drawn from nine of the 10 original case study states (AZ, CO, GA, IL, KY, LA, MA, NJ, WA), plus one additional state (CA). Additionally, interviews were conducted with Medicaid managed care health plans from nine of the 10 of the original study states (AZ, CO, GA, IL, KS, KY, LA, NJ, WA). See **Figure 1**.

In order to gain greater insight into the experiences of health care providers, we included two basic types of providers: community health centers offering comprehensive primary health care services (among which are family planning services); and providers that specialize in family planning, such as preventive reproductive health clinics whose primary funding base (unlike a community health center) is the Title X family planning program and, in a couple of cases,

private gynecology practices. Several family planning-only providers were also Planned Parenthood affiliates.

Our goal in including both community health centers and providers that limit their services to family planning and associated reproductive health services was to determine whether there are differences in the managed care/family planning provider relationship when the provider offers a full array of primary care. For example, the challenges associated with making referrals for physical and mental health conditions covered by the plan but not part of a preventive reproductive health regimen might be greater in the case of family planning-only providers, simply because community health centers presumably (if in-network) would be able to treat most conditions identified during a reproductive health exam. Similarly, we hypothesized that community health centers, which have a long history of managed care participation, might be more likely to relate to plans on an in-network basis.

## Findings

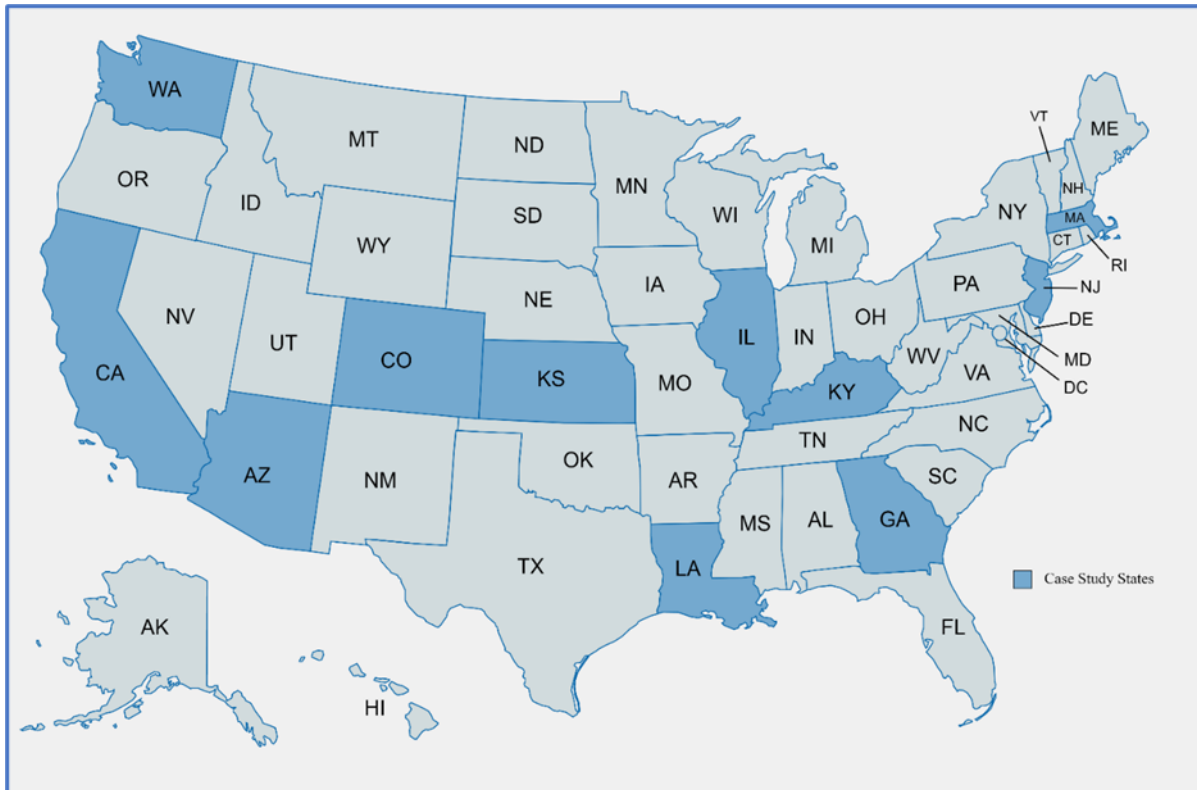
**In-network status is the norm for both community health centers and family planning-only providers, with some exceptions.**

Community health centers uniformly reported contracting with all managed care plans in their service areas. This finding is consistent with the fact that community health centers are obligated to fully participate in all forms of health insurance available to their patients.

Among family planning-only providers, managed care contracting was common, although not universal. Some family planning providers reported a more selective approach to contracting with plans in their service areas. A few family planning-only providers that also are Planned Parenthood clinics reported that they do not participate in managed care, preferring to remain independent chiefly as a result of the fact that Medicaid fee-for-service rates and payment terms are better.



**Figure 1. Case Study States**



Furthermore, several private family planning-only providers reported being dropped from certain plans.

**AZ private provider:** *"One of the things that's been a little odd is that at times I've had patients who will have a certain (Medicaid managed care) plan and will have been my patient for five years. And then suddenly... we're not contracted with them anymore unbeknownst to both the provider and the patient."*

However, the sentiment among family planning-only providers toward remaining outside managed care is by no means universal. Several Planned Parenthood clinics reported being members of plans, and at least one reported that in their view, their fee-for-service patients are left behind when their family planning providers are not fully connected to their plans. Another Planned Parenthood clinic reported joining managed care plans despite the administrative burden, because plan membership assured that their care would be in-network.

**Treating patients as in-network providers is the norm, although patients still may come for care on an out-of-network basis.**

Consistent with the general pattern of in-network status, providers reported that most of their patients are seen on an in-network basis. Providers reported that their out-of-network patients may come to them under a variety of circumstances. For example, providers reported continuing to see patients who were members of health plans for which providers were no longer network providers, in order to ensure care continuity. This choice may reflect the fact that the freedom of choice safeguard made this possible; that is, family planning providers would continue to be paid and care would continue to be covered regardless of network status. Out-of-network care could occur because patients did not know that providers had left the plan, because they were visiting from another region of the state, or because they in fact lived in another state but preferred to travel over the border to certain providers.

**CA private provider:** *"If you have Medi-Cal (California Medicaid) you can go anywhere that accepts Medi-Cal and receive family planning services regardless of in-network status. There are out-of-network Medicaid patients in southern California that come up [to us] in northern California."*

Not surprisingly, providers reported that a common form of out-of-network care is not "out-of-network" in the normal sense, but instead a function of their patients being uninsured and thus not members of plan networks. This observation by providers underscores the importance of the family planning freedom of choice safeguard. For non-family planning services, a patient who seeks care out-of-network is akin to an uninsured patient, since care is not covered in the absence of prior plan approval to obtain care from an out-of-network provider. But the freedom of choice rule means that in the case of designated family planning services, providers are assured of payment even when they are not members of plan networks. Providers subject to the requirement that they serve all patients regardless of their ability to pay (e.g., community health centers and clinics that receive Title X family planning funding) noted that they serve their uninsured patients in accordance with their obligations – but that this obviously puts a strain on their funding, since grants are limited in relation to the total need for care among uninsured patients.

### **Health plans overwhelmingly prefer network inclusion for family planning providers in their service areas.**

Despite the fact that family planning services are available to members on an out-of-network basis, managed care plans overwhelmingly view family planning as an in-network service that they seek to make available to their members. Plans indicated that their members typically use in-network family planning providers, but that out-of-network care does occur. In two states, plans reported that out-of-network care is not an issue because they take active steps to include all Medicaid-qualified family planning providers in their service areas as network providers.

In one state (Georgia), plans reported that the including all family planning providers as in-network providers was significantly simplified by the fact that a highly organized family planning provider network has instituted a centralized provider credentialing system that allows an efficient response to the credentialing step that is a prerequisite to managed care provider participation.

**GA Medicaid managed care organization:** *"There is a central credentialing body that credentials Medicaid providers in Georgia, which then brings all providers in-network. Once a provider meets the credentialing requirement, then the providers are connected directly to all Medicaid MCOs and are picked up by all four MCOs. The MCOs meet weekly and bring all newly credentialed Medicaid providers into Medicaid managed care."*

Plans indicated a preference for in-network status for providers but readily recognized that members may go out-of-network from time to time, a service use pattern that did not appear to cause concern. In only one of our study states does out-of-network use of family planning services appear to be the norm: in New Jersey, all Planned Parenthood clinics have elected to remain out-of-network, a choice that the state supports through generous fee-for-service rates.

### **Member education regarding their free choice of providers is limited.**

By and large, plans reported that they do not provide specific member education regarding the family planning freedom of choice option. This could help explain why out-of-network use of providers is a relatively limited occurrence, except as noted in New Jersey - where out-of-network status for Planned Parenthood providers is the custom. Washington state is a notable exception to this pattern, since plans are obligated to include information about the freedom of choice option in their member handbooks. Plans in Illinois and Kentucky also reported that their handbooks provide members with information about their option to receive family planning care from out-of-network providers.



**Health plans generally perceive in-network status as a status that family planning providers wish to maintain. However, there appear to be differences between the perceptions of health plans and of family planning providers themselves.**

Medicaid plans view in-network status as a desirable advantage for family planning providers, although there are important differences within the provider community. From a plan perspective, the chief benefit of in-network status for providers would be a higher volume of members who use in-network providers, ensuring a steady revenue stream. Furthermore, in many states, especially those in which managed care is a long-time phenomenon, Medicaid beneficiaries, like other insured populations, have become accustomed to the requirement that covered services be obtained from in-network providers. Other benefits of in-network status from plans' perspective could be easier billing and more rapid claims processing, as out-of-network providers may experience delays in payment, since plans tend to give their in-network providers payment priority.

**IL Medicaid managed care organization:**

*"Typically, providers who accept the Medicaid rate want to be in-network with plans, because they have access to provider portals that allow them to look up claims, EMRs, etc."*

**WA Medicaid managed care organization:**

*"Providers have really embraced managed care and the plans. Most providers prefer to have that working relationship with plans, as opposed to be worried about things being carved out."*

While plans virtually uniformly saw value in-network membership, provider viewpoints differed by state. In some states such as Washington state, Arizona, and Illinois, providers see network status as the desirable norm in order to have access to the "extras" (as they put it) that come with membership such as access to patient portals and electronic health records, along with, of course, higher revenues and more rapid pay. However, even in these highly-managed-care oriented states, there may be providers that do not want to be

network members because of the responsibilities that come with membership, in particular, a billing infrastructure.

In one state, provider respondents indicated that plans created an affirmative barrier for family planning providers that remained out-of-network by imposing a prior authorization requirement on members who sought to use an out-of-network family planning clinic. (This strategy appears to be inconsistent with federal law, which strictly limits the use of prior authorization or utilization controls over beneficiary access to family planning services.<sup>9</sup>) Providers in another state also reported past use of prior authorization for out-of-network access, but that the issue had been resolved. Beyond these isolated instances, providers did not report utilization management-induced barriers to coverage and payment, and plans interviewed for this study uniformly reported that they do not use prior authorization for family planning services.

In other states, which follow the model exemplified by New Jersey, direct fee-for-service by out-of-network family planning providers continues to be straightforward and relatively simple. This choice on the state's part to maintain a strong, transparent direct payment policy likely would have the effect of limiting the network membership incentives that would exist in states that prefer that their family planning providers be in-network. For those states that would prefer that their family planning providers be in-network, states may be more likely to delegate to plans the responsibility of paying for out-of-network family planning services. In these states, family planning providers could find themselves having to navigate multiple plans as out-of-network providers, something that could be considerably more challenging than maintaining in-network status.

In sum, the choices made by states themselves regarding whether to actively support or discourage out-of-network status for family planning providers might be expected to considerably influence how family planning providers themselves view in-network participation. In a state such as New Jersey, in

other words, provider preferences may be distinctly different from those among providers in states such as Washington state, Arizona, or Georgia, where the state has embraced managed care as its family planning norm.

**Health plans by and large perceive family planning as a key element of primary care, although some view family planning as occupying its “own pillar.”**

Health plans’ views of family planning may influence the ways in which they choose to relate to family planning providers, including recruitment into network membership, payment terms, and integration into a “whole person” approach to health care. Most of the plans we interviewed prefer their members to remain in-network for family planning services because they view family planning as part of a comprehensive program of primary care services. These plans view their primary care network providers as health homes for their patients and appear to place special value on providers that can offer the full range of primary health care, including family planning. Plans also appear to place value on primary care providers, like community health centers, that can offer the full range of primary care to patients.

**WA Medicaid managed care organization:** *“[We] think of family planning as fundamental to primary care, so family planning is not where our integration efforts lie. [We are] much more focused on integrating behavioral health into primary care. We have a strong philosophy that primary care should be the center for all care... as much as it should be easy for individuals to get family planning services at their primary care provider, we prefer that.”*

On the other hand, in no case did plans appear to favor family planning providers that offered the full range of primary care to the exclusion of family planning providers that specialize in family planning and preventive reproductive health. In other words, the fact that plans might have preferred members to receive all of their primary care, including family planning, from a single health home did not lead them to discourage

membership for independent family planning providers. Indeed, all plans indicated active support for in-network status for both comprehensive care clinics and family-planning-only providers. For example, in New Jersey, where Planned Parenthood providers remain outside managed care networks, our plan respondent indicated that New Jersey plans preferred that Planned Parenthood providers join their networks but could not persuade them to do so. Plans in other states all indicated a preference for family planning clinics as in-network providers; no plan respondents preferred that family planning-only providers remain out-of-network in order to limit their access to plan members. Plans wanted all family planning providers in their service areas to belong to their provider networks given their clear understanding of the importance of family planning to members’ health.

Despite the preference for in-network status for family planning providers, some plans see the value of a separate “family-planning-only” provider status because it simplifies the task of recognizing and paying claims for family planning services. Presumably, this reflects the fact that federal Medicaid law provides an enhanced federal financial participation rate for services designated as family planning services; as a result, separate billing and claims payment simplifies the task of reporting services to the state for relevant in the case of the ACA expansion population, for whom all medical assistance claims are federally funded at the 90 percent enhanced federal funding rate). Plans in at least one state observed, as well, that family planning-only providers were more likely to offer the full range of family planning methods including LARCS, making them more comprehensive sources of care. This observation is consistent with earlier research showing the relationship between Title X family planning grant funding and the on-site availability of comprehensive family planning services.<sup>10</sup>

**IL Medicaid managed care organization:** *“We might see more streamlining and effectiveness if there was a pillar called ‘family planning’. Whether doctors or nurse practitioners, it would allow more*

*effectiveness in the way that [providers] code or in terms of purchasing LARCs or how 340B is used. When a woman goes there, they will know they can get that service, and would allow doctors to refer where else they need it."*

### **CMS's artificial distinction between family planning and family planning-related services has caused confusion and elevated risks of non-treatment.**

As discussed in the report from the first phase of our study,<sup>11</sup> the Centers for Medicare and Medicaid Services (CMS) draws an artificial distinction between "family planning services" that are eligible for 90 percent federal funding, and services that are merely "family planning-related" - and thus, while customarily furnished in a family planning setting, qualify for federal payment only at the normal state contribution rate (i.e., between 50% and 75%). This effort to distinguish between the two levels of care for federal funding purposes is inconsistent with 2010 amendments to Medicaid that expanded the definition of family planning services and has become irrelevant in the case of services to the ACA expansion population, which qualify for 90 percent federal financing for all services. We concluded in the phase one report of our study that such an artificial distinction could lead to payment denials to family planning providers for key services such as sexually transmitted infection (STI) diagnosis and treatment, HPV immunization, and HIV assessment and counseling, because these services are not considered "family planning".

Our second phase interviews offered confirmation of the confusion caused by the attempt to separate out "family planning-related" services. Such a separation carries serious public health risks (i.e., the absence of on-the-spot treatment for an STI by a family planning provider that will not get paid, in favor of a referral to another plan provider that risks never being completed) and can lead plans to withhold payment for certain services on the ground that their relationship to family planning providers covers only designated "family planning" services. Such an issue might be addressed in network contract negotiations, but this does not

help out-of-network providers who are paid for only a limited range of care. Moreover, our interviews did not suggest that providers and plans view the contract negotiation process as a major opportunity to develop real policies for assuring seamless treatment for health conditions carrying major personal and public health consequences.

**CO managed care organization:** *"Issues don't arise with routine family planning services such as contraception, but arise when there are 'gray area codes'... such as STI treatment. Sometimes we have to go back and forth to determine if the benefit should be included. We need a robust list of codes (from the state) to fix this."*

Multiple providers and plans indicated that the patchwork approach to family planning and family planning-related services creates coverage and billing "gray areas" around family planning. Because certain treatments are considered only "related," these treatments would lack a family planning billing code signaling enhanced federal funding. Rather than recognizing two levels of codes and covering and billing both, it appears that certain procedures simply go unpaid, which of course would elevate the risk of non-treatment.

It is also worth noting that the confusion appeared to affect not only family planning-only providers that might qualify for coverage and reimbursement for only "family planning" services, but also, strikingly, community health centers, which universally are in-network providers for a full range of comprehensive primary care services. Community health centers presumably would be paid for all contract services they furnish, regardless of the federal funding rate for each service. And yet, they too reported difficulties in billing for services that were furnished as part of their family planning services but that were classified only as "related."

In sum, our discussions with providers and plans on this point felt like we were dealing with a federal policy that was creating a cascade of unforced errors. During our study, the Colorado legislature was considering legislation that would expand the scope of Medicaid-covered services

**Figure 2: Key Findings from Provider and Health Plan Interviews**

### **Network Status**

- 1) In-network status is the norm for both community health centers and family planning-only providers, with some exceptions.
- 2) Treating patients as in-network providers is the norm, although patients still may come for care on an out-of-network basis.
- 3) Health plans overwhelmingly prefer network inclusion for family planning providers in their service areas.
- 4) Health plans generally perceive in-network status as a status that family planning pro-viders wish to maintain. However, there appear to be differences between the perceptions of health plans and of family planning providers themselves.

### **Member Education**

- 5) Member education regarding free choice of providers is limited.

### **Family Planning as Primary Care**

- 6) Health plans by and large perceive family planning as a key element of primary care, although some view family planning as occupying its “own pillar.”

### **Payment**

- 7) CMS’s artificial distinction between family planning and family planning-related services has caused confusion and elevated risks of non-treatment.
- 8) Value-based payment strategies in a family planning context appear to be at an early stage where family planning is concerned.

### **Accessibility**

- 9) Family planning providers generally report making all birth control methods available, but some problems are noted.
- 10) Both plans and providers report that access to family planning remains a problem.
- 11) Plans and providers quickly adapted to providing telehealth services during the COVID-19 pandemic, which helped to maintain access to care.

### **Addressing Social Determinants of Health**

- 12) Health risk screening and referrals for medical and social services represent a significant activity for family planning providers, but provider capabilities to address SDOH varied.

available in family planning settings in order to ensure that the care aligns with patient needs rather than the artificial federal funding distinction. Washington state also has taken steps to clarify enhanced coverage and payment for care furnished in family planning settings, regardless of the level of federal funding.

### **Family planning providers generally report making all birth control methods available, but some problems are noted.**

Most family planning providers, especially community health centers, report that they are able to make all birth control methods available, but occasional problems do arise.

One issue noted by a provider in one state was an inability to insert a LARC for 10 days following an abortion. There appears to be no federal prohibition against immediate and voluntary LARC insertion following an abortion; the rationale for this waiting period is not readily apparent. Separately, evidence from another study suggests that some states do not appear to permit family planning providers to stock and dispense 12 months of oral contraceptives during a visit,<sup>12</sup> although this is the recommended family practice standard.<sup>13</sup> Barriers against this practice were not reported in this study, however.

### **Both plans and providers report that access to family planning remains a problem.**

The plans interviewed in this study reported that network adequacy is the subject of regular monitoring, and that recruitment efforts are ramped up in response to any perceived shortages. Of course, recruitment alone may not ease the situation in service areas where there exist actual, on-the-ground shortages of available providers, but the need to maintain an adequate family planning network was widely noted. Plans in Kentucky, Kansas, and Louisiana reported that their rural service areas experience underlying shortages of family planning providers. How plans and providers have sought to respond to these shortages (e.g. incentives to existing network providers to add mobile services; the provision of family planning services via telehealth in remote

areas; etc.) was not clear.

**LA community health center:** *"Rural clinics have major barriers for services access... there may not be clinic for 70 miles. This is not specific to family planning."*

Across all states, plans and providers noted the serious problems that arise as a result of the lack of transportation, a particular issue for adolescent patients. Also of note were reported barriers tied to the lack of telephones and language differences. Again, the exact strategies used to address these situations (such as mobile clinics to serve schools, expanded transportation, expanded interpreter services and cultural outreach; etc.) were not clear.

**CA community health center:** *"The b i g g e s t barrier is transportation... even if it is covered, and the health plans do their best to work with patients to get transportation. However, in our area, Lyft will not pick minors up. The driver will ask, 'How old are you? Oh you're not 18?', and then turn around and leave. So now that patient has missed that appointment."*

**MA community health center:** *"90% of our patients speak Spanish, and there are a lot of language barriers. A lot of specialists require patients to have own interpreter and that can be hard for patients to find."*

Importantly, plans and providers across multiple states indicated a desire for their states to target more attention on expanding access to family planning services through greater availability and more focused efforts to remove barriers related to language, culture, and transportation. Several explicitly noted the value of family planning payment reform as a means of bringing more resources to bear on accessibility.

### **Plans and providers quickly turned to telehealth during the COVID-19 pandemic, which has helped to maintain access to care.**

While all interviewed providers offered telehealth services during the pandemic, community health centers and Title X-funded clinics were better able to institute telehealth quickly than the private



providers. Most offered counseling and prescriptions, including self-administered Depo Provera, and had patients come in for an in-person visit when they desired LARC insertion. Several noted the beneficial access effects of telehealth, especially for rural areas. Like providers, plans saw the benefits of covering and paying for telehealth services.

**WA private provider:** *"In many ways, [telehealth] has been an improved process for those individuals who were driving four hours just for well women care, or for women who need to take a call in their car during a work break."*

**IL community health center:** *"[Telehealth] made it even easier to connect with younger women since they were able to just call providers at their convenience, and not involve a parent to get to an appointment in-person."*

**NJ community health center:** *"Telehealth is especially handy if patients call-in with a problem, or need a quick call with a provider to discuss something like side effects, or for a patient with multiple kids."*

Several providers also noted that the pandemic led to staffing losses when staff members left to work for other health care providers offering more competitive salaries.

**Health risk screening and referrals for medical and social services represent a significant activity for family planning providers, but provider capabilities to address social determinants of health (SDOH) varied.**

Community health centers uniformly noted that health risk screening and referrals for social and other medical services are a central part of their family planning programs. Private providers also voiced support for these activities, although they noted their uncertainty over the effectiveness of their referrals. This is not surprising given the fact that, unlike community health centers, most office-based clinical practices are not configured to make SDOH activities aimed at promoting access to follow-up health care, health related services, and social services a central component of their

activities.

The differences in provider responses on social determinant follow-up activities points to the importance of SDOH activities in a family planning context, as well as the potential differences in the scope of on-the-ground care depending on the family planning provider type. These on-the-ground differences suggest the importance of efforts to support family planning providers that may not have in-house capabilities to undertake SDOH-related activities.

**CA community health center:** *"In every visit, we screen with PRAPARE, refer for social determinant needs in-house – to counselors, to get enrolled in SNAP, TANF, WIC, etc., and offer bus passes as needed. Will call directly for resources if not available in-house."*

**Value-based payment strategies in a family planning context appear to be at an early stage where family planning is concerned.**

Most plans reported that they are not yet testing value-based payment strategies with their family planning providers, although a few indicated that they are starting to do so. Plans in Kentucky and Arizona noted early planning for the use of value-based payments to encourage the use of LARCs, particularly in the context of postpartum care. Plans in Kansas are considering payment incentives in connection with STI treatment.

Other plans in New Jersey, Washington state, Illinois, Colorado, and Louisiana noted that the use of targeted payment reforms in family planning was not yet a major issue, either because they did not perceive the need to prioritize the introduction of strategies in a family planning context or because providers preferred simple, non-incentivized payments.



## Conclusion and Recommendations

These interviews, as a follow-up to our in-depth Medicaid managed care contract analysis, point to several conclusions summarized in **Figure 3**.

**Although family planning provider networks appear to be the norm, continued access to out-of-network care remains an extremely important guarantee. As such, member education on the freedom of choice provision should be required and billing guides should clarify the services covered under this guarantee.**

From this study, it is evident that all health plans view family planning provider networks as part and parcel of their responsibility to build provider networks generally. At the same time, this study is a reminder that the freedom of choice guarantee, which has been part of Medicaid managed care policy since 1981, continues to serve a highly useful role since the policy enables states, plans, and providers to accommodate the key preferences of important stakeholders in a non-disruptive fashion.

As we also saw in our initial first phase of this study, the policy appears to cause no real problems for plans or states, nor does it appear to carry any inherent adverse consequences other than requiring potentially additional payment and coordination steps. The guarantee appears to be an active part of formal Medicaid policy in only one state (New Jersey) and for only one specific provider group (Planned Parenthood), and the policy appears to work smoothly, presumably in part because the state assumes direct payment responsibility and does not delegate the task to its plans. Other than indicating a preference for network membership, plans do not appear to object and gave no indication that the policy has impeded their efforts to otherwise build family planning provider networks using other providers such as community health centers. Whatever the benefits of integration might be, they clearly are not enough in this state to cause either the state or

the providers to seek a shift in policy.

At the same time, even in other states, the freedom of choice policy continues to play an essential role. From a beneficiary perspective, the policy allows a reasonable approach for ensuring access to a vital clinical and public health service and gives beneficiaries flexibility to maintain cross-state travel patterns or address personal emergencies that may arise when outside their own plan's service area. From a plan perspective, the freedom of choice guarantee accommodates health plans that elect not to offer family planning as a contract service, one of the original rationales for including the policy in the 1981 Medicaid reforms.

Because the freedom of choice policy remains a key aspect of Medicaid managed care, the fact that beneficiaries are seldom apprised of their plan membership rights should be a matter of concern. Neither CMS health plan member information transparency rules nor the overwhelming majority of state purchasing agreements require information to plan members regarding family planning freedom of choice, and a change in both federal and state policy in this regard is strongly warranted. In addition, providers and plans have flagged that beneficiaries' full access to the freedom of choice provision can be threatened by the general confusion over "family planning" vs "family planning-related" billing codes – specifically, which codes are covered for out-of-network Medicaid providers. To dispel this confusion and ensure full access to the provision, states could ensure that plans operate under billing guides that clarify which family planning and family planning-related services are covered among out-of-network Medicaid providers.

**States would have widespread support to pursue family planning integration as a basic feature of Medicaid managed care. Therefore, states could encourage a robust approach to family planning provider integration within plans' service areas as a basic contracting expectation.**

This study reinforces the finding from our phase one report that family planning is regarded as a

**Figure 3: Key Recommendations**

- 1) Although family planning provider networks appear to be the norm, **continued access to out-of-network care** remains an extremely important guarantee. As such, **member education** on the freedom of choice provision should be required and **billing guides** should clarify the services covered under this guarantee.
- 2) Despite the benefits of the freedom of choice safeguard, states, plans and providers all appear to **value and pursue family planning integration as a basic feature** of Medicaid managed care. Therefore, **states could encourage a robust approach to family planning provider integration within plans' service areas as a basic contracting expectation.**
- 3) Utilization management remains a matter of concern. For this reason, **plan contracts should include a clear prohibition against the use of prior authorization prior to obtaining family planning services from an out-of-network, Medicaid-qualified family planning provider, as allowed under federal law.**
- 4) Given the support of plans and providers, states should consider **payment reforms that encourage innovation in the accessibility and quality of family planning services**, such as additional service sites and hours, programs targeted to certain high-risk populations, and enhanced follow-up care for certain high-risk patients.
- 5) The 2016 CMS policy of "family planning" versus "family planning-related" services remains an unforced error with significant adverse consequences. **The policy should be reversed, and the family planning benefit definition should be modified to expand the full range of services identified in federal law.**

core feature of Medicaid managed care. Integration appears to be not only expected but desired by plans and by most providers. In this respect, the 1981 safeguard, which remains essential as a basic access protection, does not appear to have disrupted an active and long-term effort on the part of states, plans, and providers to fully integrate family planning into comprehensive managed care arrangements. The emphasis on integration is underscored by the preference expressed by a number of plans for family planning as part of the comprehensive offerings of members' health homes, although a number of plans expressed appreciation for independent, family planning-only providers because of the emphasis they bring to family planning as a distinct service and their tendency to offer more comprehensive services.

Not only do plans appreciate integration, but providers also appear to by and large embrace and value in-network membership because of the access it offers to a higher volume of members, higher Medicaid revenue, integration into plan protocols, and access to members' health information and electronic health records. Because health plans tend to prioritize payment to in-network providers, plan membership may also result in faster pay, a critical consideration given the extent to which publicly-funded family planning providers rely on Medicaid to support their financial operations. Furthermore, given the collective agreement on importance of family planning, states and plans could address the concern on the part of family planning providers that reimbursement rates are simply too low. States would find widespread support for addressing family planning and family planning-related reimbursement rates, so that providers can keep offering these crucial services without financial strain.

**Utilization management remains a matter of concern. For this reason, states could clarify the types of utilization management approaches that are considered permissible. Plan contracts should include a clear prohibition against the use of prior**

**authorization prior to obtaining family planning services from an out-of-network, Medicaid-qualified family planning provider, as allowed under federal law.**

Utilization management in a family planning context was reported rarely, and when it arose, it did so only in the context of member access to out-of-network providers as a result of the freedom of choice guarantee. Under the 1981 amendments, this curb on freedom of choice is impermissible, and any evidence that utilization management is being used to limit the right of plan members to seek covered family planning services from the Medicaid-qualified provider of choice is cause for concern. As we noted in our phase one study report, the absence of clear contract terms regarding coverage, the freedom of choice guarantee, access to care, and the provision of information to plan members about this safeguard can contribute to situations in which plans inappropriately steer members away from their provider of choice. There is a need for clear federal policies regarding free choice of providers that prohibit interference with freedom of choice, which runs counter to the safeguard.

**Given the support of plans and providers, states should consider payment reforms that encourage innovation in the accessibility and quality of family planning services, such as additional service sites and hours, programs targeted to certain high-risk populations, and enhanced follow-up care for certain high-risk patients.**

One of the more striking aspects of our interviews was the high degree of support for the development of strategies to strengthen and improve the accessibility and quality of family planning services. Plans and providers alike recommended that states place greater priority on developing and implementing value-based purchasing strategies in connection with family planning. At the same time, it was not immediately clear why plans and providers themselves could not test value-added payment strategies, such as rewarding efforts to expand service locations or

hours, increase the use of telehealth, or offer special services for hard-to-reach populations such as adolescent members or members with special cultural or language needs. In rural areas where access appears to be a matter of elevated concern, incentives aimed at supporting mobile services would appear desirable.

A state certainly could lead a cross-plan effort to design and test out family planning value purchasing incentives in order to bring a coordinated approach to the effort. A statewide health plan association might also tackle the issue as a basic quality improvement undertaking, much the way state and national health plan associations have targeted social determinant of health investments as a high-value plan undertaking. At the same time, state-led access and quality improvement strategies could help avert plan concerns surrounding the potential for private collaboration to be viewed as anti-competitive.

In terms of the nature of plan and provider interests, our discussions suggest widespread interest in a combination of up-front core investments that help providers to expand services, add access points, and implement telehealth, coupled with a cross-plan value payment strategy that can support these investments, once made. Where family planning is concerned, the case for such a strategy is always strong - but especially now, with continued access to abortion services such a cause for concern, especially among the poorest and most at-risk women. Such a strategy, given the support for family planning integration, would place Medicaid managed care at the forefront of efforts to improve family planning accessibility and quality at a particularly critical time.

**The 2016 CMS policy of family planning versus family planning-related services remains an unforced error with significant adverse consequences. The policy should be reversed, and the family planning benefit definition should be modified to expand the full range of services identified in federal law.**

In our earlier report, we raised concerns about the 2016 CMS policy that attempts to distinguish between “family planning” services that qualify for special enhanced federal funding (90 percent FMAP) and “family planning-related” services that, while customarily furnished in family planning settings, do not qualify for enhanced funding. We pointed out that this policy increasingly has lost its immediate financial meaning, since all services for the ACA Medicaid expansion population, now in place in 38 states and the District of Columbia, qualify for 90 percent federal funding. This means that the brunt of the financial disincentive to furnish comprehensive family planning services falls on traditional populations including adolescents and the very poorest Medicaid beneficiaries.

Family planning services are mandatory for Medicaid-enrolled children and adults alike. But separate family planning “related” services might not be, since among these services are STI treatment, HPV vaccines, and HIV testing and counseling. These services all would be mandatory for all beneficiaries under 21 as an EPSDT benefit. These services also would qualify as pregnancy-related for pregnant and post-partum beneficiaries and are mandatory for the ACA expansion population as part of the law’s essential health benefit package. But for adults who are eligible for Medicaid under traditional categories (i.e., very low-income parents and people with disabilities), immunizations recommended by the Advisory Committee on Immunization Practice (ACIP) and potentially preventive HIV counseling would be optional. Thus, by drawing a distinction between “family planning” and “family planning-related” services, CMS not only has sought to avoid what today would be de minimus financial exposure but has drawn an entirely artificial, clinically inappropriate distinction among services that are customarily furnished in family planning settings and that are not only clinically appropriate but also essential to health. CMS policy has the potential to set off a chain of interference with access to high-quality, clinically appropriate, cost-effective health care, in other words.

This study confirms our concerns. Providers report difficulty billing for and getting paid to provide “related” services because they lack a “family planning” billing code. Obviously the absence of billing codes for these services is a matter that states can readily address, by assigning billing codes and instructing their contractors to pay these claims regardless of family planning setting (in-network or out-of-network). As our findings point out, at least two states have made an effort to eliminate the risk of such an outcome.

But the core of the problem lies in the 2016 CMS policy itself. Purely for reasons of minimizing federal 90 percent financial exposure for “family planning” services, it would appear, the agency has fabricated a distinction among family planning services. As noted, the “related” policy as a means of reducing the federal government’s exposure to enhanced Medicaid family planning payments has lost all meaning in the case of the ACA adult expansion population and thus its impact falls entirely on populations for whom the enhanced ACA payment rate is not available, including children, adolescents, and traditional adults – among the very poorest and most vulnerable Medicaid beneficiaries. The nominal savings that accrue to the federal government from perpetuating this policy are dwarfed by the risks of delays or interruptions in STI treatment, HPV immunization, and HIV assessment. It is an understatement to conclude that this 2016 policy runs counter to value-based health care.

At this pivotal time for Medicaid and family planning, CMS should be pursuing policies that advance the triple aim – the right care in the right settings at the right time. Maintaining a distinction between family planning and family planning-related services achieves precisely the opposite result and should be reversed, along with a renewed effort by the agency to encourage states to promote policies that maximize access to high-quality family planning services using managed care as a model.

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## Appendix 1: Advisory Committee

| Organization   | Name                   | Title   |
|--|------------------------|---|
| Aetna  | Dr. Andrea Bennett     | Senior Director, Public Policy & Government Affairs |
| Anthem   | Dana Thomas            | Senior Government Relations Director                |
| Coalition to Expand Contraceptive Access   | Susan Moskosky         | Associate Director                                  |
| Community Health Development of Texas  | Rachel Gonzalez Hanson | CEO   |
| Cornell Scott-Hill Health Center   | Michael Taylor         | CEO   |
| Health Management Associates   | Chuck Milligan         | COO   |
| IL Department of Healthcare and Family Services                                  | Theresa Eagleston      | Director  |
| Jacobs Institute for Women's Health Policy, The George Washington University     | Dr. Susan Wood         | Director  |
| Kaiser Family Foundation   | Laurie Sobel           | Associate Director for Women's Health Policy        |
| National Association of Community Health Centers                                 | Kathy McNamara         | Associate VP of Clinical Affairs                    |
| National Association of Community Health Centers                                 | Dr. Ron Yee            | Chief Medical Officer                               |
| National Center for Medical-Legal Partnerships, The George Washington University | Bethany Hamilton       | Director  |