



Center for Medicaid, CHIP and Survey & Certification

SMDL#10-013
ACA# 4

July 2, 2010

**RE: Family Planning Services Option
and New Benefit Rules for Benchmark Plans**

Dear State Health Official:

This letter is intended to provide guidance on the implementation of two Medicaid benefits-related provisions in the Affordable Care Act (ACA); P.L. 111-148, as amended by the Health Care and Education Recovery Act of 2010; P.L. 111-152. Both provisions were effective as of March 23, 2010.

This letter provides guidance on *section 2303 of ACA: State Eligibility Option for Family Planning Services*, which establishes a new Medicaid eligibility group and the option for States to begin providing medical assistance for family planning services and supplies to individuals eligible under this new group. Under this new option, Federal funding will be available for States to provide coverage under the State plan for family planning and family planning-related services and supplies to individuals (men and women) that States could previously offer only through demonstration projects.

Additionally, this letter provides guidance on *section 2001(c) of ACA: Medicaid Coverage for the Lowest Income Populations*, which makes certain benefit changes that were enacted as part of the Affordable Care Act to benchmark plans.

STATE ELIGIBILITY OPTION FOR FAMILY PLANNING SERVICES

Background

Since 1972, States have been required to provide family planning services and supplies to Medicaid populations. Prior to ACA, States did not have the option to provide family planning services and supplies under their Medicaid State plans to individuals otherwise ineligible for Medicaid, including parents with incomes above State eligibility levels and non-disabled adults who were not caring for children. Because the provision of such services has been found to be cost effective for the Medicaid program, the Secretary of Health and Human Services has granted targeted section 1115 family planning demonstrations to permit States to cover family planning services and supplies for individuals not otherwise eligible for Medicaid. With the enactment of ACA, States now have the option to offer, under State plan authority, eligibility for family planning coverage for individuals who were previously ineligible for Medicaid.

The New Family Planning Eligibility Group

Section 2303 of ACA establishes a new optional categorically needy group that became effective on March 23, 2010. Specifically, section 2303(a)(1) of ACA establishes a new eligibility group under section 1902(a)(10)(A)(ii)(XXI) of the Social Security Act (the Act). Individuals eligible under the new family planning group are individuals (men and women):

- Who are not pregnant; and
- Whose income does not exceed the income eligibility level established by the State.

Note that the income level established by the State may not exceed the highest income level for pregnant women under the State's Medicaid or CHIP State plan. For purposes of determining eligibility and complying with section 1902(a)(17)(B) of the Act, States have the option to consider only the income of the applicant or recipient. Additionally, States may determine income eligibility for individuals under this family planning option by using the same methodology that would apply for pregnant women. This includes the methodology that counts the applicant as a household of two (or more depending on the presence of others in the family) when determining income eligibility.

In addition, the State has the option of including in this new, optional group, individuals who would have been eligible for an approved section 1115 family planning demonstration, had they applied for such demonstration on or before January 1, 2007, using the eligibility standards and procedures imposed by the State at that time. States must not restrict eligibility based on age. Under standard Medicaid rules, however, States may limit services based on medical necessity.

Some of the individuals that a State might cover under this new option (depending on their income) may be eligible for a more comprehensive set of benefits as States implement Medicaid and other coverage expansions under the ACA. Taking up the new family planning eligibility group does not preclude or in any way affect receipt of the increased matching rate (based on the requirements in effect when this group becomes mandatory in 2014). CMS will issue separate guidance on the matching rate provisions in the new health insurance reform legislation.

Benefits Available to Individuals in the New Family Planning Group; Applicable Federal Matching Rates

The services available for this new group are described in section 2303(a)(3) of ACA, amending section 1902(a)(10)(G) of the Act. Services available are limited to family planning services and supplies described in section 1905(a)(4)(C), as well as such "medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting." We are interpreting this language to provide for coverage of both family planning and family planning-related services, maintaining their longstanding separate definitions.

- Family planning services and supplies are described in section 1905(a)(4)(C). These services and supplies are reimbursable at the 90 percent matching rate under the new family planning option. These are the same services that are covered at the 90 percent matching rate for other Medicaid State plan beneficiaries. Individuals in this new family

planning group must receive the same 1905(a)(4)(C) services that other categorically needy individuals receive.

- Family planning-related services are medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting. These services can be covered under the new option but are reimbursable at the State's regular Federal medical assistance percentage (FMAP) rate.

Family Planning-Related Services

Family planning-related services have historically been considered those services provided in a family planning setting as part of or as follow-up to a family planning visit. Such services are provided because they were identified, or diagnosed, during a family planning visit. As noted above, these services are reimbursable at the State's regular FMAP rate.

The following are examples of family planning-related services:

- Drugs for the treatment of sexually-transmitted diseases (STD) or sexually-transmitted infections (STI), except for HIV/AIDS and hepatitis, when the STD/STI is identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs may be covered. In addition, subsequent follow-up visits to rescreen for STIs/STDs based on the Centers for Disease Control and Prevention guidelines may be covered.
- Some States and family planning programs encourage men to have an annual visit at the office/clinic. Such an annual family planning visit may include a comprehensive patient history, physical, laboratory tests, and contraceptive counseling.
- Drugs for the treatment of lower genital tract and genital skin infections/disorders, and urinary tract infections, when the infection/disorder is identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs may be covered.
- Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to a family planning service in a family planning setting. An example of a preventive service could be a vaccination to prevent cervical cancer.
- Treatment of Major Complications

The following are examples of treatment of major complications that States may cover:

- Treatment of a perforated uterus due to an intrauterine device insertion;
- Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or,
- Treatment of surgical or anesthesia-related complications during a sterilization procedure.

It should be noted that for persons who have had a sterilization, States must cover family planning-related services that were provided as part of, or as follow-up to, the family planning visit in which the sterilization procedure took place.

Presumptive Eligibility

A new section 1920C of the Act, as added by section 2303(b) of ACA, gives States that have adopted the new family planning eligibility group the option of also providing a period of presumptive eligibility based on preliminary information that an individual meets the eligibility criteria for family planning services in new section 1902(ii). The presumptive eligibility period allows health providers to receive reimbursement (and States to receive Federal matching funds) for medical assistance for an individual who has been determined presumptively eligible by a qualified entity during a specific period. In general, a qualified entity is an entity that is eligible to receive payments under the approved State plan and is determined by the State agency to be capable of making presumptive eligibility determinations. Please note that the State may limit the classes of entities that may become qualified entities to ensure program integrity.

The qualified entity must inform the State agency of the presumptive eligibility determination within 5 working days after the determination is made and inform the presumptively eligible individual that he or she must file an application for assistance no later than the last day of the month following the month during which the determination is made. The State agency must provide the qualified entities with necessary forms for the individual to file an application and information on how to assist individuals in completing the forms. Documentation for various factors of eligibility, such as citizenship, are not required for the presumptive determination, but will be requested when the application is filed. The State's reasonable opportunity period for submission of citizenship documentation also begins at this point. Please refer to the letter to State Health Officials (SHO# 09-016) issued December 28, 2009 for further guidance on citizenship documentation. Nothing prevents a State from using a simplified application form as its presumptive eligibility form. This can streamline the process and help ensure that all individuals are considered for ongoing eligibility.

The actual presumptive eligibility period begins with the date on which the qualified entity determines that the individual is eligible based on preliminary information. The presumptive eligibility period ends with and includes the earlier of:

1. The day on which a formal eligibility determination is made for the family planning program under the Medicaid State plan; or
2. For an individual who does not file an application by the last day of the month following the month during which the individual was determined presumptively eligible, the last day of that month is the last day of the presumptive eligibility period. For example, if an individual is determined presumptively eligible on April 1, but the individual does not file an application by May 31, then the last day of the presumptive eligibility period is May 31.

For individuals determined to be presumptively eligible under this category, medical assistance shall be limited to family planning services and supplies described in section 1905(a)(4)(C), and at the State's option, medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting (family planning-related services, as described above).

Converting Family Planning Section 1115 Demonstrations

Currently, 22 States have approved stand-alone section 1115 family planning demonstrations. If a State with a demonstration wants to adopt the new State plan family planning optional group, it would need to submit a SPA to select this option (see below). In addition, the State should notify its project officer and the CMS Regional Office State representative of its request to terminate the family planning demonstration at such time as the SPA is approved. Since States would be shifting a population from the demonstration to the Medicaid State plan, the State would *not* need to submit a demonstration phase-out plan as defined in the special terms and conditions. However, the State should notify individuals that they are no longer enrolled in a section 1115 research and demonstration project, but instead are now enrolled in the Medicaid State plan option for family planning services. In addition, the State must submit a final report on its demonstration no later than 12 months after terminating the demonstration. With respect to budget neutrality, CMS would apply budget neutrality terms through the effective date of the SPA.

Please note, if a State that was providing family planning services through a section 1115 demonstration on March 23, 2010 chooses the State plan option, it must, at a minimum, maintain current eligibility until the State has established a health benefit exchange under ACA (or October 1, 2019 for individuals under age 19) due to statutory maintenance of effort requirements under the American Recovery and Reinvestment Act (ARRA) of 2009 (Pub.L. 111-5) and ACA.

Five States have comprehensive section 1115 demonstrations that include a targeted family planning component. If a State wishes to cover the family planning population under the Medicaid State plan, it should submit a SPA and a Demonstration amendment removing the population as of the effective date of the SPA.

A State electing to keep this population in its targeted or comprehensive demonstration may do so as well. However, the State may need to submit an amendment to the demonstration in order to renegotiate budget neutrality.

Other Applicable Rules

All rules applicable under the Medicaid program in general apply to this new optional eligibility group, including rules relating to cost sharing, citizenship, immigration, and third party liability.

In addition, a State that elects to extend eligibility to this group must include consideration of this new eligibility group when it determines whether an individual who has qualified under another eligibility category continues to qualify for Medicaid. For example, under existing regulatory requirements, before terminating coverage for a woman who has been eligible for

Medicaid as a pregnant woman and will lose such eligibility at the end of the 60-day post partum period, the State must perform an ex parte review to determine whether the woman would be eligible under another eligibility group. If the State elects to offer coverage under the new family planning eligibility group, this review must include consideration of whether the woman is eligible under that new group.

Submission of SPAs

To implement this new optional group, States will need to submit an amendment to their Medicaid State plan. We are ready to work with States interested in adopting this new option and to assist States in amending their plans.

RECENT CHANGES TO MEDICAID BENCHMARK BENEFITS

Background

On April 30, 2010, a final rule on State Flexibility for Medicaid Benefit Packages was published in the Federal Register (75 FR 23068), which revised the December 3, 2008, final rule (73 FR 73694). This final rule became effective on July 1, 2010 and implements provisions of section 6044 of the Deficit Reduction Act of 2005 (Pub. L. 109-171), which added a new section 1937 that allows States to amend their Medicaid State plans to provide for the use of benefit packages other than the standard benefit package for certain populations. These alternative benefit packages are referred to as benchmark and benchmark-equivalent benefit packages. The April 30 final rule also incorporates provisions of ARRA and implements provisions of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (Pub. L. 111-3). This final rule delineates what benefit packages qualify as benchmark packages, what would constitute a benchmark-equivalent package, and which specific services must be included in a benchmark benefit plan or provided as an additional service. However, the rule did not address the ACA provisions relating to benchmark plans, including sections 2001(c) and 2303(c) which amended section 1937 of the Act. This letter describes the new ACA provisions in 2001(c) and 2303(c) that were effective upon enactment (March 23, 2010).

Specifically, section 2001(c) of ACA adds mental health services and prescription drug coverage to the list of required services that must be included in benchmark-equivalent coverage. In addition, section 2303(c) of ACA requires States providing medical assistance to individuals described in section 1905(a)(4)(C) of the Act, through enrollment in benchmark or benchmark-equivalent coverage, to cover family planning services and supplies.

Implementation

The above services are requirements of benchmark and benchmark-equivalent coverage for States that provide coverage through such plans. Accordingly, States that choose to provide medical assistance through benchmark or benchmark-equivalent coverage must now comply with all provisions of the April 30, 2010 final rule, as well as the provisions of section 2001(c) and 2303(c) of ACA described in this letter. CMS will apply these requirements in reviewing new State plan amendments and monitoring currently approved State Medicaid plans. Note that beginning in 2014, benchmark and benchmark-equivalent plans must begin providing at least

essential health benefits, as described in Section 1302(b). These issues will be addressed at a later date.

We hope this information will be helpful. CMS is available to provide technical assistance to States with existing benchmark plans to ensure the plans comply with these benefit rules. Questions regarding this guidance may be directed to Ms. Vikki Wachino, Director, Family and Children’s Health Programs Group, at (410) 786-5647. We look forward to our continuing work together as we implement this important legislation.

Sincerely,

/S/

Cindy Mann
Director

cc:

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