

TO: Interested Parties

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DATE: October 25, 2010

SUBJECT: CMS Guidance on Family Planning State Plan Amendments

The Affordable Care Act (ACA) was signed into law on March 23, 2010.¹ Sec. 2303 of that legislation allows states to amend their state Medicaid plans to expand eligibility for family planning services and supplies to individuals who are not pregnant and who have an income that does not exceed the income-eligibility level set by the state for coverage for pregnancy-related care (Appendix A). In the intervening months, the Centers for Medicare and Medicaid Services (CMS) has taken three sets of actions:

- On July 2, CMS issued formal guidance to the states on the implementation of this provision (Appendix B);
- On August 27, CMS circulated two draft preprints, one on the provision in general and one on covered services (Appendix C), for states to use to submit a state plan amendment (SPA); and
- On August 31, CMS convened a conference call with state officials to discuss the provision and provide additional guidance.

This memo summarizes the guidance CMS has provided to states, both in writing and verbally, to date. As additional guidance is provided by CMS, we will update this memo with the goal of maintaining a comprehensive description of CMS guidance on the family planning SPAs.

Eligibility and Enrollment

Under the ACA, states may set the eligibility level for family planning up to the highest level for pregnant women in place under either the state's Medicaid or Children's Health Insurance Program (CHIP) state plan. The July 2 guidance specified that states seeking to amend their state Medicaid plans must include all individuals in the state who are not pregnant and who meet the income eligibility criteria established by the state. As a result, the guidance indicated that states may not exclude individuals based on age. In the August 31 call, CMS also specified that states may not exclude individuals based on gender. In practice, this means that states may not exclude adolescents or men from a family planning SPA, even if these groups are not covered in a family planning waiver that has already been obtained by a state.

¹ P.L. 111-148, Mar. 23, 2010.

Income Eligibility

In order to ensure that all women who would be eligible for Medicaid- or CHIP-covered pregnancy-related care can be eligible for Medicaid-covered family planning services under a SPA, the July 2 guidance makes clear that a state may use the same methodology for determining income eligibility for family planning as it uses for pregnancy-related care. This includes, according to the guidance, counting the applicant as a household of two (or more, depending on the presence of others in the family) when determining income eligibility. States choosing to use the same methodology for determining eligibility for family planning as they use for pregnancy-related care would need to apply that methodology to both women and men. The conversion of income eligibility levels to account for considering an applicant as a household of two (or more, depending on the presence of others in the family) was described in an earlier memo from the Guttmacher Institute (Appendix D).

In making eligibility determinations, states have the option to consider only the income of the applicant and not the income of other family members.

Presumptive Eligibility

According to the ACA, states may utilize presumptive eligibility in their family planning SPAs. States may permit certain qualified family planning providers to grant temporary eligibility to individuals; this temporary eligibility may be determined using a shortened application. Providers must notify the state agency of any individual granted presumptive eligibility within five days of making that determination; providers will be paid for care provided to individuals during their presumptive eligibility period, and states will be able to receive federal matching funds. Documentation of citizenship is not required for an individual to be determined to be presumptively eligible, according to the July 2 guidance.

In order to continue to be enrolled, an individual determined to be presumptively eligible must file an application for Medicaid family planning coverage no later than the last day of the month following the month in which the presumptive eligibility determination is made. Documentation of citizenship is required at the point at which an application for Medicaid family planning coverage is made. The presumptive eligibility period ends at the earlier of either the date at which a formal eligibility determination is made or, for individuals who do not file an application, the application deadline date.

Enrollment

On the August 31 call, CMS indicated that in the case of an individual who has applied for full-benefit Medicaid or CHIP coverage but who the state determines meets the eligibility requirements only for the more limited family planning expansion, the state must offer that individual coverage under the family planning expansion. To fulfill this requirement, a state might, for example, include a question on the initial Medicaid application asking applicants if they wish to be considered for enrollment in the family planning expansion if they are found not to be eligible for full-benefit Medicaid coverage. Alternatively, a state could query individuals found ineligible for full-benefit Medicaid to determine if they wish to be enrolled in the family planning expansion. In all cases, however, enrollment in the family planning program is entirely voluntary on the part of any individual.

Also on the August 31 call, CMS indicated that a state may not explicitly exclude individuals who have been sterilized. However, it would appear that a state's application materials could describe the package of services covered under the family planning expansion (see below) and give an individual the option of applying. In the case of an individual who has been sterilized, it is likely that nothing in that package would be appropriate for them and they most likely would not seek to be enrolled.

In the case of an individual who applies for the more limited family planning expansion but who the state determines meets the requirements for full-benefit Medicaid coverage, the state must enroll that individual in the broader coverage, according to CMS staff on the August 31 call with states. This will require that the state establish a process for screening applicants to the family planning expansion to determine whether they may be eligible for broader coverage. Having imposed this requirement, it appears that CMS will need to work with states to craft a way to put it into effect that does not disrupt the practice of allowing enrollment in the family planning expansion at the point of service or inhibit the use of shortened enrollment forms for the family planning expansion (in much the same way that shortened forms are widely used for purposes of determining eligibility for pregnancy-related care under Medicaid).² This requirement also will need to be implemented in a way that neither compromises confidentiality nor impedes the ability of a state to consider only the income of the applicant and not the income of other family members.

Other Applicable Rules

According to the July 2 guidance, having private insurance coverage is not a bar to an individual's eligibility for coverage under a family planning SPA. In the case of an individual who has other insurance coverage, the state's usual requirements relating to third-party liability apply. (Under standard Medicaid practices, individuals who have third-party coverage, such as private insurance, can be enrolled, but reimbursement must be sought through that coverage first, making Medicaid the payer of last resort.)

Although the guidance does not mention any exceptions to the third-party liability requirements, existing federal statutes and regulations provide a "good-cause exception" to these requirements.³ Specifically, the regulations provide an exception to the requirement that individuals identify and provide information to assist in the pursuit of third parties who may be liable to pay for care and services under the plan when "it is anticipated that cooperation will result in reprisal against, and cause physical or emotional harm to, the individual or other person."⁴ This exception, which allows patients to seek health services without jeopardizing their confidentiality, is critical to protecting a patient's safety and to ensuring access to family planning services.

The guidance also indicates that all general Medicaid rules apply to family planning SPAs. On the August 31 call, CMS staff specified that states may neither impose premiums as a condition of enrollment in a family planning expansion nor cap enrollment under their SPA. States must

² Ranji U, et al., *State Medicaid Coverage of Family Planning Services: Summary of State Survey Findings*, Menlo Park, CA: The Henry J. Kaiser Family Foundation, 2009, <<http://www.kff.org/womenshealth/upload/8014.pdf>>.

³ 42 USC 1396k; 42 CFR 433.147.

⁴ 42 CFR 433.147(c)(2).

follow the same requirements for citizenship documentation for enrollment in a SPA as required for enrollment in full-benefit Medicaid.

'Grandfather' Clause

According to the July 2 guidance, states that have an existing family planning waiver and that convert from a waiver to a SPA may continue to enroll individuals who would have been eligible under the eligibility standards and procedures used under the state's waiver on or before January 1, 2007.

Eligibility for Enhanced Federal Match under Health Care Reform

Under the ACA, states will be required to expand Medicaid eligibility by 2014 to individuals with an income at or below 133% of the federal poverty level; states will receive an enhanced federal matching rate for these newly eligible people. The July 2 guidance makes it clear that expanding eligibility for family planning will not affect a state's ability to claim this enhanced matching rate if these individuals subsequently become eligible for the more comprehensive set of benefits.

Maintenance-of-Effort

Under the maintenance-of-effort provisions of the 2009 stimulus legislation⁵ and the ACA, states are required to maintain their eligibility levels for Medicaid until a certain point in time (anticipated to be January 1, 2014, for the ACA's requirement).⁶ By law, this requirement applies to full-benefit Medicaid as well as Section 1115 demonstration waivers. The July 2 guidance states that those states that were providing family planning services through a waiver on March 23, 2010, and that choose to take up a SPA must at least maintain current eligibility under the maintenance-of-effort provisions of the ACA. However, CMS has not specifically addressed the question some states have raised as to whether this maintenance-of-effort requirement applies to a state that has an expiring waiver but does not choose to implement the SPA option.

Covered Services

CMS has provided guidance on coverage of both family planning services and supplies and family planning-related services under SPAs.

Family Planning Services and Supplies

According to the July 2 guidance, states are required to cover the entire package of family planning services and supplies that are covered under their full-benefit Medicaid program. States may be reimbursed at the special 90% federal reimbursement rate for these family planning services and supplies.

⁵ The American Recovery and Reinvestment Act (ARRA) (P.L. 111-5; February 17, 2009), as amended by the Education, Jobs and Medicaid Assistance Act (P.L. 111-226; August 10, 2010).

⁶ The stimulus maintenance-of-effort provision expires June 30, 2011. The ACA's requirement expires once the HHS Secretary deems the states' health insurance Exchanges fully operational, which is anticipated to be on January 1, 2014.

Family Planning–Related Services

In addition, states must also cover family planning–related services, which are defined as “medical diagnosis and treatment services that are...provided in a family planning setting as part of or as follow-up to a family planning visit.” States may be reimbursed at their regular federal medical assistance percentage (FMAP) for family planning–related services. According to the August 31 call, states are required to cover at least *some* (but not all) family planning–related services in their SPAs. The guidance cites several examples of family planning–related services:

- Drugs may be covered for the treatment of STIs (except for HIV/AIDS and hepatitis), lower genital tract and genital skin infections/disorders and urinary tract infections, when diagnosed during a family planning visit. A follow-up visit for the treatment/drugs may be covered. In addition, states may cover follow-up visits to re-screen for STIs based on CDC guidelines.
- An annual visit for men (which may include a comprehensive patient history, physical, laboratory tests and contraceptive counseling) may be covered.
- Other diagnostic, treatment and preventive services routinely provided pursuant to a family planning service in a family planning setting may be covered. The guidance cites the human papillomavirus (HPV) vaccine (to prevent cervical cancer) as an example of a preventive service that may be covered. (Although the guidance does not specifically mention colposcopy and repeat Pap tests, they are covered under some existing waivers.)
- States may cover treatment of major complications, such as treatment of a perforated uterus due to an IUD insertion.
- For persons who have had a sterilization procedure, states must cover family planning–related services provided as part of or as follow-up to the family planning visit in which the sterilization took place.

Also during the August 31 call, CMS staff indicated that, as under full-benefit Medicaid, states are required to cover transportation services needed by individuals enrolled under a family planning SPA. Transportation must be covered to the same extent that it is covered under full-benefit Medicaid in the state, even if it had not been covered in a family planning waiver that had been obtained by the state.

As under full-benefit Medicaid, states may not impose cost-sharing requirements for family planning services, according to July 2 guidance. CMS has not been clear about whether cost-sharing could be required for family planning–related services.

According to CMS staff on the August 31 call, states must provide the same provider reimbursement under a family planning SPA as is provided under full-benefit Medicaid, including the use of prospective payment rates for services provided by Federally Qualified Health Centers (FQHCs). Nonetheless, it appears that CMS may permit states to provide additional compensation to providers specifically for any enrollment assistance activities they provide for clients to facilitate enrollment under a SPA.

Process for States Seeking to Apply for a SPA

A state seeking to apply for a family planning SPA may use the preprints distributed by CMS on August 27. Those preprints may be used by states while still in draft form. The timeline and process for obtaining a SPA was described in an earlier memo from the Guttmacher Institute (Appendix E).

The July 2 guidance included a number of provisions relating to states that have a family planning waiver and are seeking to avail themselves of the new option:

- States seeking to convert need to apply for a SPA.
- A state seeking to convert from a waiver to a SPA will not be required to submit a phase-out plan for the waiver, since it is essentially shifting the population, not discontinuing their eligibility. However, states must notify enrollees that they are now covered under the state plan option. States will be required to submit a final report on the waiver within 12 months of terminating a waiver; CMS will apply budget neutrality through the effective date of the SPA, which means that a state seeking to convert from a waiver to a SPA will need to make sure that its waiver has been in effect long enough to reach budget neutrality. (SPAs are not required to be budget neutral.)
- A state must maintain at least the eligibility provided for under its waiver (see above re: maintenance of effort).
- The state should notify the CMS project officer for its waiver and the CMS regional office of its desire to terminate its demonstration waiver as of the start date of the SPA.

A state that has a family planning expansion that is part of a comprehensive 1115 Medicaid waiver must both submit an application for a SPA and move to amend its waiver to remove the family planning component. Removing this component may require some renegotiation of budget neutrality for the comprehensive waiver.

On October 1, CMS issued a letter to State Medicaid Directors that attempts to streamline the SPA process by establishing procedures for resolving issues that are identified during consideration of a SPA but that are not integrally related to the SPA itself (Appendix F). In the past, when these types of issues have arisen in the course of the agency's review of a SPA application, it has often delayed consideration of the SPA itself. The October 1 letter attempts to expedite that process by, in some cases, separating consideration of these issues from the review of the SPA, so that approval of the SPA can proceed.

Appendix A
Statutory Language

which a diagnosis of terminal illness has been made” after “hospice care”.

SEC. 2303. STATE ELIGIBILITY OPTION FOR FAMILY PLANNING SERVICES.

(a) **COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.**—

(1) **IN GENERAL.**—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)), as amended by section 2001(e), is amended—

- (A) in subclause (XIX), by striking “or” at the end;
- (B) in subclause (XX), by adding “or” at the end; and
- (C) by adding at the end the following new subclause:
 “(XXI) who are described in subsection (ii) (relating to individuals who meet certain income standards);”.

(2) **GROUP DESCRIBED.**—Section 1902 of such Act (42 U.S.C. 1396a), as amended by section 2001(d), is amended by adding at the end the following new subsection:

“(ii)(1) Individuals described in this subsection are individuals—

“(A) whose income does not exceed an income eligibility level established by the State that does not exceed the highest income eligibility level established under the State plan under this title (or under its State child health plan under title XXI) for pregnant women; and

“(B) who are not pregnant.

“(2) At the option of a State, individuals described in this subsection may include individuals who, had individuals applied on or before January 1, 2007, would have been made eligible pursuant to the standards and processes imposed by that State for benefits described in clause (XV) of the matter following subparagraph (G) of section subsection (a)(10) pursuant to a waiver granted under section 1115.

“(3) At the option of a State, for purposes of subsection (a)(17)(B), in determining eligibility for services under this subsection, the State may consider only the income of the applicant or recipient.”.

(3) **LIMITATION ON BENEFITS.**—Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)), as amended by section 2001(a)(5)(A), is amended in the matter following subparagraph (G)—

(A) by striking “and (XV)” and inserting “(XV)”; and

(B) by inserting “, and (XVI) the medical assistance made available to an individual described in subsection (ii) shall be limited to family planning services and supplies described in section 1905(a)(4)(C) including medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting” before the semicolon.

(4) **CONFORMING AMENDMENTS.**—

(A) Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)), as amended by section 2001(e)(2)(A), is amended in the matter preceding paragraph (1)—

- (i) in clause (xiv), by striking “or” at the end;
- (ii) in clause (xv), by adding “or” at the end; and

(iii) by inserting after clause (xv) the following:

“(xvi) individuals described in section 1902(ii).”

(B) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)), as amended by section 2001(e)(2)(B), is amended by inserting “1902(a)(10)(A)(ii)(XXI),” after “1902(a)(10)(A)(ii)(XX).”

(b) PRESUMPTIVE ELIGIBILITY.—

(1) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1920B the following:

“PRESUMPTIVE ELIGIBILITY FOR FAMILY PLANNING SERVICES

“SEC. 1920C [42 U.S.C. 1396r–1c]. (a) STATE OPTION.—State plan approved under section 1902 may provide for making medical assistance available to an individual described in section 1902(ii) (relating to individuals who meet certain income eligibility standard) during a presumptive eligibility period. In the case of an individual described in section 1902(ii), such medical assistance shall be limited to family planning services and supplies described in 1905(a)(4)(C) and, at the State’s option, medical diagnosis and treatment services that are provided in conjunction with a family planning service in a family planning setting.

“(b) DEFINITIONS.—For purposes of this section:

“(1) PRESUMPTIVE ELIGIBILITY PERIOD.—The term ‘presumptive eligibility period’ means, with respect to an individual described in subsection (a), the period that—

“(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1902(ii); and

“(B) ends with (and includes) the earlier of—

“(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or

“(ii) in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

“(2) QUALIFIED ENTITY.—

“(A) IN GENERAL.—Subject to subparagraph (B), the term ‘qualified entity’ means any entity that—

“(i) is eligible for payments under a State plan approved under this title; and

“(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

“(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities in order to prevent fraud and abuse.

“(c) ADMINISTRATION.—

“(1) IN GENERAL.—The State agency shall provide qualified entities with—

“(A) such forms as are necessary for an application to be made by an individual described in subsection (a) for medical assistance under the State plan; and

“(B) information on how to assist such individuals in completing and filing such forms.

“(2) NOTIFICATION REQUIREMENTS.—A qualified entity that determines under subsection (b)(1)(A) that an individual described in subsection (a) is presumptively eligible for medical assistance under a State plan shall—

“(A) notify the State agency of the determination within 5 working days after the date on which determination is made; and

“(B) inform such individual at the time the determination is made that an application for medical assistance is required to be made by not later than the last day of the month following the month during which the determination is made.

“(3) APPLICATION FOR MEDICAL ASSISTANCE.—In the case of an individual described in subsection (a) who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the individual shall apply for medical assistance by not later than the last day of the month following the month during which the determination is made.

“(d) PAYMENT.—Notwithstanding any other provision of law, medical assistance that—

“(1) is furnished to an individual described in subsection (a)—

“(A) during a presumptive eligibility period; and

“(B) by a entity that is eligible for payments under the State plan; and

“(2) is included in the care and services covered by the State plan,

shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1905(b).”.

(2) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(47) of the Social Security Act (42 U.S.C. 1396a(a)(47)), as amended by section 2202(a), is amended—

(i) in subparagraph (A), by inserting before the semicolon at the end the following: “and provide for making medical assistance available to individuals described in subsection (a) of section 1920C during a presumptive eligibility period in accordance with such section”; and

(ii) in subparagraph (B), by striking “or 1920B” and inserting “1920B, or 1920C”.

(B) Section 1903(u)(1)(D)(v) of such Act (42 U.S.C. 1396b(u)(1)(D)(v)), as amended by section 2202(b), is amended by inserting “or for medical assistance provided to an individual described in subsection (a) of section 1920C during a presumptive eligibility period under such section,” after “1920B during a presumptive eligibility period under such section.”.

(c) CLARIFICATION OF COVERAGE OF FAMILY PLANNING SERVICES AND SUPPLIES.—Section 1937(b) of the Social Security Act (42 U.S.C. 1396u–7(b)), as amended by section 2001(c), is amended by adding at the end the following:

“(7) COVERAGE OF FAMILY PLANNING SERVICES AND SUPPLIES.—Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark-equivalent coverage under this section unless such coverage includes for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.”.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on the date of the enactment of this Act and shall apply to items and services furnished on or after such date.

SEC. 2304. CLARIFICATION OF DEFINITION OF MEDICAL ASSISTANCE.

Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended by inserting “or the care and services themselves, or both” before “(if provided in or after”.

Subtitle E—New Options for States to Provide Long-Term Services and Supports

SEC. 2401. COMMUNITY FIRST CHOICE OPTION.

Section 1915 of the Social Security Act (42 U.S.C. 1396n) is amended by adding at the end the following:

“(k) STATE PLAN OPTION TO PROVIDE HOME AND COMMUNITY-BASED ATTENDANT SERVICES AND SUPPORTS.—

“(1) IN GENERAL.—**[As revised by section 1205 of HCERA]** Subject to the succeeding provisions of this subsection, beginning October 1, 2011, a State may provide through a State plan amendment for the provision of medical assistance for home and community-based attendant services and supports for individuals who are eligible for medical assistance under the State plan whose income does not exceed 150 percent of the poverty line (as defined in section 2110(c)(5)) or, if greater, the income level applicable for an individual who has been determined to require an institutional level of care to be eligible for nursing facility services under the State plan and with respect to whom there has been a determination that, but for the provision of such services, the individuals would require the level of care provided in a hospital, a nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases, the cost of which could be reimbursed under the State plan, but only if the individual chooses to receive such home and community-based attendant services and supports, and only if the State meets the following requirements:

“(A) AVAILABILITY.—The State shall make available home and community-based attendant services and supports to eligible individuals, as needed, to assist in accomplishing activities of daily living, instrumental activities of

Appendix B

July 2 CMS Guidance on Family Planning SPAs



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:

CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medical and Children’s Health

Ann C. Kohler
NASMD Executive Director
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Debra Miller
Director for Health Policy
Council of State Governments

Alan Weil, J.D., M.P.P.
Executive Director
National Academy for State Health Policy

Christine Evans, M.P.H.
Director, Government Relations
Association of State and Territorial Health Officials

Appendix C

Draft Preprints for Family Planning SPAs

State/Territory _____

Citation

Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

**1902(a)(10)(A)(ii)(XXI)
1902(ii)**

Individuals who are *not* pregnant and whose income does not exceed the State established income standard of _____% of the Federal Poverty Level. This amount does not exceed the highest income limit for pregnant women in this State Plan, which is _____% of the Federal Poverty Level.

In determining eligibility for this group, the State considers only the income of the applicant or recipient.

Note: Services are limited to family planning services and family planning-related services as described in section 4.c(ii) of Attachment 3.1-A.

1920C

Presumptive Eligibility for Family Planning:

The State provides a period of presumptive eligibility for family planning services to individuals determined by a qualified entity, based on preliminary information from the individual, described in the group the State has elected to make eligible under the above option. The period of presumptive eligibility ends on the earlier of the date a formal determination of Medicaid eligibility is made under 1902(a)(10)(A)(ii)(XXI), or, when no application has been filed, the last day of the month following the month during which the qualified entity determines the individual presumptively eligible.

TN No. _____

Approval Date _____

Effective Date _____

Supersedes TN No. _____

Revision:

ATTACHMENT 3.1-A

Page

OMB NO.:

State/Territory _____

Citation

Family Planning Benefits

1905(a)(4)(C)

4.c.(i) Family planning services and supplies for individuals of child-bearing age and for individuals eligible pursuant to Att. 2.2-A, B, if this eligibility option is elected by the State.

Provided: No limitations With limitations

Please describe any limitations:

4.c.(ii) Family planning-related services provided under the above State Eligibility Option

TN No. _____ Approval Date _____ Effective Date _____

Supersedes TN No. _____

Revision:

CMS-PM-

ATTACHMENT 2.2-A

Page 2

OMB NO.:

State _____

Citation

Groups Covered

In addition to family planning services, the State covers family planning-related services to such individuals during the period of presumptive eligibility.

DRAFT

TN No. _____

Approval Date _____

Effective Date _____

Supersedes TN No. _____

Appendix D

Guttmacher Memo on Household Income



TO Interested Parties
FROM Rachel Benson Gold and Adam Sonfield
DATE April 6, 2010
SUBJECT Achieving Parity in Eligibility for Reproductive Health Services Under Medicaid

The recently enacted health care reform legislation includes a provision giving states the option to amend their state Medicaid plans to extend eligibility for family planning services and supplies to individuals who otherwise would not be eligible. According to the House Energy and Commerce Committee, this provision is designed to enable state Medicaid programs to cover family planning services and supplies for any individual who would be eligible for Medicaid coverage of pregnancy-related care.¹ Research conducted by the Guttmacher Institute has shown that establishing parity in eligibility for family planning and for pregnancy-related care maximizes the cost-savings for the federal government and the states.²

Achieving that goal of parity is complicated by the fact that a pregnant woman is considered two people for purposes of determining her income eligibility for Medicaid. Because of this, a state seeking to achieve parity would need to adjust its income ceilings for family planning to equal the income threshold that would be applied to that woman if she were pregnant.

The table below makes that adjustment for the income ceilings (expressed as a percent of the federal poverty level) most often used by states in determining eligibility for Medicaid-funded pregnancy-related care.* It shows the income ceiling for family planning for women in families of different sizes needed to correspond to the state's income ceiling for pregnancy-related care.

If the state's income ceiling for pregnancy-related care is **133% FPL**, the corresponding income ceiling for women seeking family planning is

- 179% for a single woman (family of 1)
- 167% for a woman in a family of 2
- 160% for a woman in a family of 3

* This adjustment was done by taking the highest income a pregnant woman could have and qualify for Medicaid-funded pregnancy-related care and then translating that dollar amount into a proportion of poverty for that same woman if she were not pregnant. For example, in a state where the ceiling for pregnancy-related care is 133% of poverty, a single, pregnant woman in a family of 1 (a woman with no children) could have an income up to \$19,378. This dollar amount translates into an income threshold of 179% of the federal poverty level for the same woman if she were not pregnant. The impact of pregnancy on poverty-level status varies according to the size of the family: The smaller the family size, the larger the effect.

If the state's income ceiling for pregnancy-related care is **185% FPL**, the corresponding income ceiling for women seeking family planning is

249% for a single woman (family of 1)

232% for a woman in a family of 2

223% for a woman in a family of 3

If the state's income ceiling for pregnancy-related care is **200% FPL**, the corresponding income ceiling for women seeking family planning is

269% for a single woman (family of 1)

251% for a woman in a family of 2

241% for a woman in a family of 3

If the state's income ceiling for pregnancy-related care is **250% FPL**, the corresponding income ceiling for women seeking family planning is

336% for a single woman (family of 1)

314% for a woman in a family of 2

301% for a woman in a family of 3

If the state's income ceiling for pregnancy-related care is **300% FPL**, the corresponding income ceiling for women seeking family planning is

404% for a single woman (family of 1)

377% for a woman in a family of 2

361% for a woman in a family of 3

¹ America's Affordable Health Care Choices Act of 2009, Report of the Committee on Energy and Commerce on H.R. 3200 together with dissenting views, available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_reports&docid=f:hr299p1.111.pdf, p. 616.

² Frost JJ, Sonfield A and Gold RB, Estimating the Impact of Expanding Medicaid Eligibility for Family Planning Services, *Occasional Report*, New York: Guttmacher Institute, 2006, No. 28.

Appendix E

Guttmacher Memo on SPA Process



MEMO

TO Interested Parties
FROM Rachel Benson Gold
DATE March 23, 2010
SUBJECT Implementation of the Medicaid Family Planning State Option in Health Care Reform

A groundbreaking provision included in the recently enacted health care reform legislation will allow states to expand Medicaid eligibility for family planning services without having to go through the cumbersome process of obtaining a federal waiver. This memo provides background on the issue, details the provisions included in the health care reform legislation, outlines what a state without a waiver needs to do to expand eligibility and discusses what the Centers for Medicare and Medicaid Services (CMS) can do to facilitate the process. We are currently investigating issues around the conversion of an existing waiver into a state plan amendment and will be sending you a second memo on that subject shortly.

Background

The federal Medicaid statute determines the basic contours of the program. It defines the principles that undergird Medicaid and lays out the standards for a required benefit package. Each state has considerable latitude to design and operate its own program within these relatively broad federal parameters. The details of each state's program is described in its own state Medicaid plan. The state plan is the "comprehensive written statement" that sets forth how the state will comply with the federal requirements; it is the heart of the compact between the state and the federal government.¹ The federal statute provides for federal matching funding for states with an approved state Medicaid plan.

Once a state's Medicaid plan is approved by CMS, the state has two avenues for changing that plan. The first is to seek a federal waiver. States take this route when they are seeking to make a change inconsistent with existing federal requirements; the state is therefore seeking to have these requirements waived in this instance. Under the statute, waivers are to be used to demonstrate promising new innovations.² Over the last 15 years, 27 states have sought and received federal waivers to extend eligibility for family planning services under the program to individuals who otherwise would not be eligible.³ These programs have demonstrated that they can greatly expand access to care while generating significant cost-savings to the federal and state governments.⁴

As one would expect when the goal is to make changes that are inconsistent with the federal statute, the process for obtaining a waiver is complex and cumbersome. Most significantly, waivers are time-limited; they are granted for an initial five-year period and then renewed in three-year increments. Although not required by law or statute, CMS has historically required

that waivers be budget neutral to the federal government; that is, they cannot cost the federal government more than it would otherwise have spent in the absence of the waiver. Waiver applications are given extensive review within CMS, and are examined by the Office of Management and Budget (OMB) as well. CMS also requires that waivers have an extensive evaluation component, consistent with their role as demonstration initiatives.

The second avenue available for a state seeking to change its program is to obtain federal approval to change, or amend, its state Medicaid plan. States use this approach when they want to change their programs in ways that are consistent with federal law and policy. For example, if a state wants to expand its program to add a new eligibility group or offer a benefit not previously covered, the state would be required to amend its state plan in order to receive federal matching funds for expenditures associated with the new group or benefit.⁵

This avenue has been made available to states in the past when a critical mass of information and experience has been developed through waivers. For example, throughout the course of the 1980s and early 1990s, most states utilized Medicaid waivers to require that at least some Medicaid recipients enroll in managed care plans. By the mid-1990s, managed care had transitioned from being a demonstration initiative to a fundamental operating principle for Medicaid, especially for low-income enrollees of reproductive age.⁶ In response, the Balanced Budget Act of 1997 included a provision that allowed states to mandate managed care enrollment by amending their state Medicaid plans, without having to obtain a federal waiver.⁷

Enter Health Care Reform

A provision included in the newly enacted health care reform legislation puts the Medicaid family planning waivers on the same path. The best summary of this provision is the one included in the report accompanying the legislation that was approved by the House Energy and Commerce Committee.⁸ According to the committee's report:

- The measure is designed to give states the option of extending coverage for family planning services and supplies to individuals who are not pregnant and whose income does not exceed an eligibility level set by the state for pregnant women under either Medicaid or the Children's Health Insurance Program (CHIP). According to the committee, this provision is designed to enable state Medicaid programs to cover family planning services and supplies for any individual who would be eligible for Medicaid coverage of pregnancy-related care.
- For purposes of this option, family planning services and supplies include medical diagnosis and treatment services provided pursuant to a family planning service in a family planning setting (including, at state option, testing and treatment of sexually transmitted infections).
- For states that already have a family planning waiver, the bill seeks to facilitate the conversion of that existing waiver into state plan amendments by allowing states to do so without modifying their existing eligibility policies. Specifically, the bill gives a state the ability to continue to use the eligibility standards and processes, including application procedures and practices, operational under a family planning waiver on or before January 1, 2007.

- The bill specifically allows states to utilize presumptive eligibility in their programs.

This provision was effective on enactment. The Secretary of the Department of Health and Human Services (DHHS) is not required to issue regulations to implement this provision.

What States Need to Do

As one would expect, given that state plan amendments (SPAs) are reserved for changes consistent with federal law and policy, the process is more streamlined than that for a state seeking to waive the requirements for federal law. SPAs do not have to be budget neutral and there is no requirement for research and evaluation. OMB generally does not participate in the process. Review is conducted mainly at the regional level, although regional offices can—and almost always do—consult with national CMS staff on questions regarding the application of federal policy. Most significantly, a SPA, unlike a waiver, is a permanent change to the state’s program; it does not need to be renewed at periodic intervals.

A brief discussion of the process for a state that does not currently have a Medicaid family planning waiver is included below. We are looking into the process for the conversion of existing waivers into SPAs and will include that information in a subsequent memo.*

In general, to amend its plan, a state must submit a draft SPA to the regional CMS office, using CMS Form 179 (Transmittal and Notice of Approval of State Plan Material).⁹ In yet another distinct difference from the waiver route, federal regulations specify a timeline for the review and approval of amendments.¹⁰ Once the regional office receives a SPA, the amendment is considered approved if CMS neither disapproves it nor makes a formal request for additional information within 90 calendar days. Although the regional office can engage in an informal dialogue with the state without affecting the timeframe, sending a formal request for additional information stops the 90-day clock. Generally, the formal “Request for Additional Information” letter (also sometime referred to as a “stop-the-clock” letter), notifies the state that if a response is not received by CMS within 180 days, the amendment will be disapproved.¹¹

When CMS receives the state’s formal response to the information request, a second clock begins, giving CMS yet another 90-day period for review. As a result, the process can sometimes be an extended one. (It is, however, likely to be more expeditious than the review process for waivers; on average it has taken 20 months between when a state applies for a family planning waiver and when federal approval is obtained.) Ultimately, however, federal law requires approval of a SPA that meets the federal state Medicaid plan requirements.¹²

* What is clear, however, is that a state that already has a waiver is not obligated to transition to a SPA. And, in fact, there might be circumstances in which a state might want to continue to operate under a waiver. This could happen if a state is providing services not provided for in the statute or if it is covering individuals (such as those with an income above the state’s ceiling for pregnancy-related care) not covered by the statute. In those cases, a state may consider either retaining its waiver in full or transitioning part of its program to a SPA while retaining a smaller waiver to “wrap around” its SPA and essentially do what cannot be done through that process. Clearly, this decision is going to have to be made on a state-by-state basis.

An approved SPA is effective on the first day of the quarter in which an approvable SPA was submitted to the regional office, even if the actual approval might have been many months later.¹³ This enables a state to claim federal reimbursement retroactive to the date on which the SPA was originally submitted.

States determine their own rules and procedures on whether and when SPAs require state legislative action or public hearings and notice. According to the National Health Law Program and the National Association of Community Health Centers, four states have provisions requiring legislative approval of SPAs (Connecticut, the District of Columbia, Missouri and New Hampshire). Two states (Kentucky and Nebraska) require notice to the legislature regarding SPAs and several other states (Alaska, Minnesota, Ohio and Vermont) have requirements for legislative notice and review of rule changes.¹⁴ However, if the experience with Medicaid family planning waivers is a guide, some states in which legislative authorization is not required are likely to seek it regardless, either because that is standard practice in the state even in the absence of a legal mandate or as a way for a legislature to ensure that a policy change occurs.

What CMS Can Do

On some occasions, CMS has moved to facilitate the process for states seeking to amend their state Medicaid plans. The recent passage of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) provides a good example of the kinds of steps CMS can take. This experience may be a good model for steps CMS may take in the coming months to facilitate states' response to the family planning state option provision in health care reform.

CHIPRA was signed into law on February 4, 2009. In addition to providing significant new funding for the critical program, the legislation gave states a host of new options that could improve coverage for millions of children and adults. As but a few examples, CHIPRA gave states the ability to streamline the eligibility process, permitted states to cover pregnant women and eliminated the five-year residency requirement for children and pregnant women who are lawfully residing in the United States.¹⁵

CMS moved swiftly to provide guidance to states seeking to implement these new provisions, many of which required them to submit SPAs. On April 17, the agency sent out a letter to state officials, a step frequently taken to communicate with state officials about important policy issues.¹⁶ This first letter summarized the major provisions of the legislation and indicated that it would be followed by a series of state health official (SHO) and state Medicaid director (SMD) letters over the coming months to provide more detailed guidance to the states. The letter also indicated that the agency planned to convene regular conference calls with states to hear their questions and implementation concerns. Finally, the letter gave states a CHIPRA-specific email address to which states could send questions related to the new law and its implementation. This letter was followed by 15 other letters; the most recent letter, sent on March 2, 2010, discusses federal matching rates.¹⁷

The second step the agency could and, in the case of CHIPRA, did take to make it easier for states to amend their state plans is to issue what is known as a preprint, a short application template for states to follow. Generally, preprints give states the ability to simply check the policy options they have selected. The agency also often uses templates to encourage states to

include some specific features in their plans. The second CMS state officials' letter, sent on May 11, just three months after the legislation was enacted, outlined the law's provisions and gave the states guidance on amending state plans, "should your state wish to take advantage of this option."¹⁸ The letter included a four-page preprint for states to use in crafting their applications for SPAs.

CMS has used preprints on several occasions in the past when it has wanted to ease the process for states. Under the Paperwork Reduction Act, OMB is required to approve the documents. States are free to use the preprint in draft form while OMB approval is pending, although CMS cannot require use of the form until it has been approved.¹⁸

The state response was swift. According to a report by the Center on Budget and Policy Priorities written for the Kaiser Commission on Medicaid and the Uninsured, by the end of 2009, 17 states and the District of Columbia submitted SPAs to adopt the CHIPRA option to cover immigrant children and/or pregnant women who have been legally residing in the United States for less than five years.¹⁹

For its part, CMS moved quickly to approve several of the SPAs. For example, New Jersey submitted a plan amendment to cover pregnant women on June 12; it was approved on September 18, but was effective retroactive to April 1, the first day of the quarter in which the SPA was submitted.²⁰ Similarly, Connecticut submitted an amendment to cover recent immigrant children on June 30; it was approved on December 18.²¹ Rhode Island's amendment to include pregnant women in its plan was submitted on April 16 and approved on December 29.²²

Over the last year, we have been in conversations with CMS about ways to move this issue forward. In January 2009, the Institute provided CMS with a template for a streamlined waiver application, which focused on streamlining the process for states seeking to expand and encouraging the promotion of the best practices that have been developed in the existing family planning waivers. Now that the health care reform legislation is a reality, we will be working with them to adapt these ideas and procedures to the SPA process.

Please feel free to contact me if you have any questions or comments; I can be reached by email at rgold@guttmacher.org or by phone at 202-296-4012.

¹ 42 CFR 430.10.

² 42 USC 1315.

³ Guttmacher Institute, State Medicaid family planning eligibility expansions, *State Policies in Brief*, 2009, <http://www.guttmacher.org/statecenter/spibs/spib_SMFPE.pdf>, accessed Mar. 23, 2010.

⁴ Gold RB et al., *Next Steps for America's Family Planning Program: Leveraging the Potential of Medicaid and Title X in an Evolving Health Care System*, New York: Guttmacher Institute, 2009, <<http://www.guttmacher.org/pubs/NextSteps.pdf>>, accessed Mar. 23, 2010.

⁵ Rudowitz R and Schneider A, *The Nuts and Bolts of Making Medicaid Policy Changes: An Overview and a Look at the Deficit Reduction Act*, Kaiser Commission on Medicaid and the Uninsured, 2006, <<http://www.kff.org/medicaid/upload/7550.pdf>>, accessed Mar. 23, 2010.

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- ⁶ Richards CL and Gold RB, *Medicaid Support for Family Planning in the Managed Care Era*, New York: The Alan Guttmacher Institute, 2001, <<http://www.guttmacher.org/pubs/medicaid.pdf>>, accessed Mar. 23, 2010.
- ⁷ P.L. 105-33, Aug. 5, 1997.
- ⁸ *America's Affordable Health Care Choices Act of 2009, Report of the Committee on Energy and Commerce on H.R. 3200, Together with Dissenting Views*, Oct. 14, 2009, p. 616, <http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_reports&docid=f:hr299p1.111.pdf>, accessed Mar. 23, 2010.
- ⁹ CMS, Transmittal and Notice of Approval of State Plan Material, Form CMS-179, <<http://www.cms.hhs.gov/cmsforms/downloads/cms179.pdf>>, accessed Mar. 23, 2010.
- ¹⁰ 42 CFR 430.10-20.
- ¹¹ For example: CMS, letter to Wyoming Office of Health Care Financing, <<http://www.cms.hhs.gov/NationalCHIPPolicy/Downloads/WYSPA6RAI.pdf>>, accessed Mar. 23, 2010.
- ¹² 42 USC 1396a(b).
- ¹³ 42 CFR 430.20.
- ¹⁴ National Health Law Program and National Association of Community Health Centers, *Role of State Law in Limiting Medicaid Changes*, <<http://www.nachc.com/client/NHELP-NACHC-St-by-St-Chart-Final.pdf>>, accessed Mar. 23, 2010.
- ¹⁵ Georgetown University Health Policy Institute, Center for Children and Families, *The Children's Health Insurance Program Reauthorization Act of 2009: Overview and Summary*, 2009, <<http://ccf.georgetown.edu/index/cms-filesystem-action?file=ccf%20publications/federal%20schip%20policy/chip%20summary%2003-09.pdf>>, accessed Mar. 23, 2010.
- ¹⁶ CMS, SHO #09-002, CHIPRA #1, <<http://www.cms.hhs.gov/SMDL/downloads/SHO041709.pdf>>, accessed Mar. 23, 2010.
- ¹⁷ CMS, SHO #10-005, CHIPRA #16, <<http://ccf.georgetown.edu/index/cms-filesystem-action?file=policy/2009%20schip%20reauth/sho10005.pdf>>, accessed Mar. 23, 2010.
- ¹⁸ CMS, SHO #09-006, CHIPRA #2, <<http://www.cms.hhs.gov/SMDL/downloads/SHO051109.pdf>>, accessed Mar. 23, 2010.
- ¹⁹ Ross DC, et al., *A Foundation for Health Reform: Findings of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents During 2009*, Kaiser Commission on Medicaid and the Uninsured, 2009, <<http://www.kff.org/medicaid/upload/8028.pdf>>, accessed Mar. 23, 2010.
- ²⁰ CMS, letter to New Jersey Department of Human Services, Sept. 18, 2009, <<http://www.cms.hhs.gov/NationalCHIPPolicy/downloads/NJSPA12ApprovalLetter.pdf>>, accessed Mar. 23, 2010.
- ²¹ CMS, letter to Connecticut Department of Social Services, Dec. 18, 2009, <<http://www.cms.hhs.gov/NationalCHIPPolicy/downloads/CTSPA7ApprovalLetter12.18.09.pdf>>, accessed Mar. 23, 2010.
- ²² CMS, letter to Rhode Island Department of Human Services, Dec. 29, 2009, <http://www.cms.hhs.gov/NationalCHIPPolicy/downloads/RI_SPA6ApprovalLetter12.29.09.pdf>, accessed Mar. 23, 2010.

Appendix F

October 1 CMS Letter on SPA Review Process

Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Center for Medicaid, CHIP and Survey & Certification

SMD #10-020

October 1, 2010

Re: Revised State Plan Amendment Review Process

Dear State Medicaid Director:
Dear State Health Official:

The Centers for Medicare & Medicaid Services (CMS) is issuing this letter to inform you of changes CMS is making in the State plan amendment (SPA) review process. These changes are being made to implement a more efficient process for the review of proposed modifications to the State Medicaid plan.

Background

Federal statute and regulations require CMS to review and approve SPAs for consistency with the requirements of Section 1902(a) of the Social Security Act (the Act) before a State may implement Medicaid program modifications. SPAs are generally transmitted to CMS as pages excerpted from the existing approved State plan containing the provisions that the State wishes to modify. CMS reviews the proposed specific amendment and all other provisions contained on the submitted State plan page(s). In addition, CMS reviews any related or corresponding State plan provisions contained elsewhere in the State plan that are integral to understanding the pages submitted. This review process may lead to the identification of existing State plan provisions that the State is not proposing to modify and that are not integral to the proposed SPA modifications but that appear to be contrary to Federal statute, regulations, or established guidance. In the past, the review process has required that any issue identified during the review of a SPA must be resolved in order to take action on the submitted SPA. In some instances, this practice has resulted in a delay in the State's authority to promptly implement the program change for which the amendment was originally submitted.

Recognizing States' need to advance modifications to their Medicaid programs, CMS has consulted with States and identified a process that will expedite the review of SPAs while ensuring that CMS and States resolve other questions that may arise. As described in detail below, States will now have the option to resolve issues related to State plan provisions that are not integral to the SPA through a separate process.

New Procedures for SPA Processing

CMS has a continuing obligation to review all provisions of a State plan amendment for compliance with Federal statute and regulations State plans, including those on submitted pages and corresponding provisions contained within the existing approved State plan. However, CMS will no longer require States to resolve those issues that may arise in the course of the review of the submitted SPA – but are not integral to the provision modified by the SPA – prior to taking action on the submitted SPA. Instead, CMS will follow the procedure described below.

- In the event that CMS identifies potentially non-compliant State plan provisions, we will discuss those provisions with the State during the initial stages of the SPA review. The State will have the option to resolve all issues during the review of the submitted SPA or to focus solely on the provision modified by the SPA, and resolve issues unrelated to the actual SPA change through a separate process.
- If the State chooses a separate process to resolve issues unrelated to the modifications proposed in the submitted SPA, and if CMS needs additional information relating to the SPA, a request for additional information (RAI) will be issued. The RAI will include only those questions or requests for information that are applicable to the SPA submitted. The SPA will not be delayed, but the decision letter communicating the disposition of the SPA will note that additional issues are being reviewed through a separate process.
- CMS will describe the specific issues and/or questions related to those provisions that are not addressed in the context of the SPA review, but are problematic, in a letter to the State Medicaid Director on or before the date of ultimate SPA disposition. In doing so, CMS will identify the statutory or regulatory provision or guidance pertaining to the issue identified. We will not pursue matters that are not based on statute, regulations, or generally available guidance. Within 90 days from the date of the letter, States should provide information that explains why the provision is consistent with Federal statute, regulation, and existing guidance, or should submit to CMS a SPA which will bring the State plan into compliance. During this time, CMS will provide technical assistance and respond to questions from the State.
- CMS may initiate formal compliance action as described in 42 CFR 430.35 at any time. However, CMS will ordinarily delay taking action pending the discussions with the State through the process described above, and may delay taking action if the State demonstrates good faith actions to come into compliance (for example, when there are implementation or State authority issues that must be resolved). As always, the formal compliance process offers States formal appeal rights through an established hearing process.

To further explain how this new process will work and to promote consistent application of the new policy, we have enclosed several examples in which the review of issues related to the State plan can be divorced from changes proposed in the submitted SPA. The examples are based on actual State plan issues we have faced and are intended to clarify how we envision this new process.

We hope you will find this information helpful. We believe this new approach will resolve many SPA processing issues and allow SPAs to be approved more quickly. We will also be taking this new approach in our review of SPAs related to the Children's Health Insurance Program (CHIP). We are committed to working with States to ensure that CMS carries out its responsibilities in ways that advance States' ability to carry out their responsibilities.

If you have any additional questions, please contact Ms. Dianne Heffron, Director, Financial Management Group, who may be reached at 410-786-3247.

Sincerely,

/s/

Cindy Mann
Director

Enclosure

cc:

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Enclosure

IMPLEMENTATION OF NEW SPA REVIEW PROCESS – EXAMPLES

The following examples represent common situations that have arisen during the review of SPAs in recent years. They are intended to provide a general overview of the review process described in the enclosed letter and to give examples of issues that are, and are not, considered integral to a SPA. The examples are not all-inclusive but are meant to give States concrete examples based on actual SPA review scenarios, and to ensure consistent implementation of the new procedures.

SECTION I – Proposed SPA Can Be Approved Before Resolution of Other Identified Issues

Example 1: A State submits a new, stand-alone reimbursement page describing a general rate reduction (or increase) for a number of different services. The submitted page may, or may not, specifically identify the services subject to the rate adjustment.

CMS Review Process - The new, stand-alone reimbursement page must list each of the specific services subject to the rate adjustment(s) and include the location (page numbers) in the State plan of the related reimbursement methodologies so that the proposed amendments can be cross-walked to the existing State plan provisions. If this information is not included, the SPA must be amended to include this information.

The underlying methodologies and related coverage provisions for the affected services will be reviewed. If CMS has questions regarding content on the related pages, e.g., existing reimbursement methodologies or coverage provisions for the affected services, these issues can be resolved through the separate process described in this letter.

Example 2: A State submits a 4.19B reimbursement page to modify the reimbursement methodology for psychologists. The existing methodology provides reimbursement to psychologists at 100 percent of the State’s physician fee schedule. The amendment reduces reimbursement for psychologist services to 80 percent of the physician fee.

CMS reviews the coverage provisions for psychologist services. CMS also reviews the coverage provisions for physician services and the existing State plan language that describes the physician reimbursement methodology. The existing physician reimbursement language in the State plan does not include the effective date of the physician fee schedule.

CMS Review Process - CMS can approve the reimbursement language for the psychologist services even though an effective date of the physician fee schedule is not included in the State plan language describing the reimbursement methodology for psychologist services. CMS will resolve the effective date issue in the State plan’s physician reimbursement methodology (the fee schedule) through the separate process described in this letter.

Example 3: A State submits a SPA to amend coverage of nurse practitioner services. As part of the review, CMS examines the nurse practitioner reimbursement methodology. CMS discovers that the existing nurse practitioner reimbursement methodology is not comprehensive because it lacks the effective date of the fee schedule.

CMS Review Process - CMS will take action on the merits of the coverage amendment in the submitted SPA. The related issue concerning the reimbursement methodology will be addressed through the separate process discussed in this letter.

Example 4: A State submits a SPA to remove coverage of dentures from the State plan. Rehabilitative services are described on the same page as the deleted denture service description. The SPA does not define the rehabilitative services nor does it identify the providers of those services.

CMS Review Process - CMS can approve the SPA to remove dentures as a covered service based on its own merits. CMS will address issues with the rehabilitative services coverage and reimbursement through the separate process described in this letter.

Example 5: A State submits a SPA for a new inpatient supplemental payment. In response to the Standard Funding Questions in the RAI, CMS identifies a possibly unacceptable provider assessment that is the funding source for another supplemental payment identified on the submitted SPA page.

CMS Review Process - CMS will take action on the SPA based on the merits of the new supplemental payment. The issues identified concerning the other supplemental payment will be addressed through the separate process described in this letter.

Example 6: A State submits a SPA that changes one of the drug classes listed in its excluded drug coverage. CMS reviews all of the other excluded drug categories listed in the approved State plan and finds several non-drug items that are included on the list.

CMS Review Process - CMS will take action on the submitted SPA based on its own merits. The additional non-drug items included on the list will be addressed through the separate process described in this letter.

SECTION II – Proposed SPA Language Must be Modified Before Approval

Example 1: A State submits a coverage SPA eliminating adult dental services. This SPA requires tribal consultation because it will reduce benefits for eligible Indians and also will reduce reimbursements to Indian health providers that provide these services to eligible Indians. The State did not consult with the federally-recognized Tribes and Indian health providers prior to submission of the SPA.

CMS Review Process - CMS cannot approve the SPA until the required tribal consultation has occurred. To approve the SPA without the required consultation would violate Executive Order 13175 and the sec. 1902(a)(73) consultation requirements, as added by the Recovery Act.

Example 2: A State submits a SPA to modify coverage of chiropractic services. There is no reimbursement methodology in the approved State plan for chiropractic services.

CMS Review Process - CMS cannot approve this SPA until the State submits a reimbursement methodology. The State would have no authority to request Federal financial participation (FFP) for expenditures associated with chiropractic services without a reimbursement methodology in the State plan.

Example 3: A State submits a SPA to modify the reimbursement methodology for nurse practitioners. During the review process, CMS discovers that the approved State plan does not provide for coverage of nurse practitioners.

CMS Review Process - CMS cannot approve the reimbursement SPA until the State submits a State plan page authorizing the coverage of nurse practitioner services. States cannot claim FFP for expenditures for services that are not covered in the approved State plan.

Example 4: A State submits a SPA to increase fee schedule payments by 10 percent for a specific provider type. Neither the existing nor the newly submitted State plan language describing the reimbursement methodology includes the effective date of the fee schedule.

CMS Review Process – Because the State plan language that describes the reimbursement methodology for the specific service under review would not be considered a comprehensive reimbursement methodology, CMS cannot approve the SPA until the effective date of the fee schedule is included in the State plan language.

Example 5: A State submits a SPA to reimburse for services provided in schools. There is no comprehensive description of the reimbursement methodology in the State plan for these services; the methodology in the SPA states only that reimbursement is based on cost and is funded with certified public expenditures. The SPA contains only a brief description of the types of costs that will be certified.

CMS Review Process - CMS cannot approve the SPA until the State's cost-identification methodologies have been reviewed and determined to be appropriate for Medicaid certification. Because the funding of the payment is based on costs incurred by a political subdivision eligible

for participation in the funding of the Medicaid program, CMS must ascertain that the costs being matched are appropriately identified and allocated to the Medicaid program.

Example 6: A State submits a SPA to extend to additional Rural Health Centers (RHC) an existing Alternative Payment Methodology (APM) which recognizes hospital deliveries as an RHC service. Payment to RHCs for hospital deliveries is inconsistent with Federal regulatory requirements because a hospital delivery is not considered an RHC service. Therefore, the SPA cannot be approved. Upon learning this, the State withdraws the SPA.

CMS Review Process - CMS may pursue a compliance action with respect to the existing problematic reimbursement methodology following the process described in 42 CFR 430.35.