DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)

PROPOSED

PUBLIC NOTICE

Federally Qualified Health Centers - Long-Acting Reversible Contraceptives

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the Delaware Code), 42 CFR §447.205, and under the authority of Title 31 of the Delaware Code, Chapter 5, Section 512, Delaware Health and Social Services (DHSS) / Division of Medicaid and Medical Assistance proposing to amend the Title XIX Medicaid State Plan regarding Federally Qualified Health Care Centers, specifically, *to increase access to Long-Acting Reversible Contraceptives.*

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to: Planning, Policy and Quality Unit, Division of Medicaid and Medical Assistance, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906, Attention: Kimberly Xavier; by email to Kimberly.Xavier@state.de.us; or by fax to 302-255-4425 by January 31, 2017. Please identify in the subject line: FQHC - LARC.

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

SUMMARY OF PROPOSAL

The purpose of this notice is to advise the public that Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) is proposing to amend the Title XIX Medicaid State Plan regarding Federally Qualified Health Care Centers, specifically, *to increase access to Long-Acting Reversible Contraceptives*.

Statutory Authority

- §1902(a)(19) of the Social Security Act, *Care and services under a Medicaid state plan be provided in a manner consistent with simplicity of administration and the best interests of beneficiaries*
- §1905(a)(4)(C) of the Social Security Act, Family Planning Services and Supplies
- §1927 of the Social Security Act, *Payment for Covered Outpatient Drugs*
- 42 CFR §440.210, *Required services for the categorically needy; family planning services*
- 42 CFR §441.20, *Family Planning Services and Supplies*
- 42 CFR §440.120, *Prescribed drugs*
- 42 CFR §447.45, *Timely claims payment*
- State Medicaid Manual, Section 4270, *Family Planning Services*

Background

Family Planning Services and Supplies

Family planning is classified as a "mandatory" benefit under Medicaid, meaning that all Medicaid programs must cover family planning, but states have considerable discretion in identifying the specific services and supplies that are included in the benefit. There is no formal definition of family planning in the Medicaid program. Rather, federal law at Section 1905(a)(4)(C) generally allows payment for "family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age who are eligible under the State plan and who desire such services and supplies." Contraception is one of the primary services included as family planning, and most states offer broad coverage for prescription contraceptive products in their Medicaid programs. Family planning providers include office-based physicians, federally qualified health centers, family planning clinic, health departments, and other clinics. Medicaid beneficiaries can obtain family planning services and supplies from any Medicaid-participating provider. This freedom of choice is maintained even if the individual is enrolled in a managed care plan.

Delaware Health and Social Services/Division of Medicaid and Medical Assistance (DHSS/DMMA) currently provides Medicaid coverage and reimbursement for family planning services and supplies, including LARCs. LARCs are long-acting reversible contraceptives, such as intrauterine devices (IUDs) and contraceptive implants. The Center for Medicaid and CHIP Services (CMCS), the U.S. Department of Health and Human Services Secretary's Advisory Committee on Infant Mortality (SACIM), the Health Resources and Services Administration, and the American Congress of Obstetricians and Gynecologists (ACOG) all recommend the use of LARCs.

States may cover LARCs through the pharmacy benefit or medical benefit. Covering LARCs through the pharmacy benefit means that dispensing pharmacies bill the state for the LARCs and applicable dispensing fees, then deliver the LARCs to providers for insertion or administration. The provider then bills the state for the furnished insertion or implantation service. In many cases this is appropriate; however, these steps may present barriers to access in some instances since this process requires the Medicaid recipient to see the provider twice: once to obtain the LARC prescription and then again for insertion or administration. While covering LARCs through the medical benefit could address these barriers to access, high upfront costs required to maintain a stock of LARCs, may deter providers from implementing this approach, resulting in barriers to access due to a potential unwillingness of providers to furnish LARCs.

Summary of Proposal

The purpose of the proposed rule is to provide a mechanism for Federally Qualified Health Centers (FQHC) to be compensated for these expensive LARCs that are not included in the FQHC's rates. This would provide FQHC's the ability to maintain an adequate stock of LARCs, thus increasing access to important family planning services for Medicaid recipients.

Summary of Proposed Changes

If implemented as proposed, the state plan amendment will accomplish the following, effective January 1, 2017: Add language to Attachment 4.19-B, Page 2, that provides a mechanism for FQHCs to receive reimbursement for distributed LARCs based on actual acquisition cost (ACC).

Public Notice

In accordance with the *federal* public notice requirements established at Section 1902(a)(13)(A) of the Social Security Act and 42 CFR 447.205 and the *state* public notice requirements of Title 29, Chapter 101 of the Delaware Code, Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) gives public notice and provides an open comment period for thirty (30) days to allow all stakeholders an opportunity to provide input on the expansion of existing nondiscrimination protections to be all-inclusive and to ensure compliance with Federal Regulation. Comments must be received by 4:30 p.m. on January 31, 2017.

Centers for Medicare and Medicaid Services Review and Approval

The provisions of this state plan amendment (SPA) relating to coverage and payment methodology for services are subject to approval by the Centers for Medicare and Medicaid Services (CMS). The draft SPA page(s) may undergo further revisions before and after submittal to CMS based upon public comment and/or CMS feedback. The final version may be subject to significant change.

Provider Manuals Update

Also, upon CMS approval, the applicable Delaware Medical Assistance Program (DMAP) Provider Policy Specific Manuals will be updated. Manual updates, revised pages or additions to the provider manual are issued, as required, for new policy, policy clarification, and/or revisions to the DMAP program. Provider billing guidelines or instructions to incorporate any new requirement may also be issued. A newsletter system is utilized to distribute new or revised manual material and to provide any other pertinent information regarding manual updates. DMAP provider manuals and official notices are available on the DMAP website: http://www.dmap.state.de.us/home/index.html

Fiscal Impact

The proposed regulation modifies Division of Medicaid and Medical Assistance's practice and procedures to assist FQHCs in administering LARCs. It does not have a fiscal impact; the policy change is budget neutral.

DMMA PROPOSED REGULATION #17-001
REVISION:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: DELAWARE
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

FEDERALLY QUALIFIED HEALTH CENTERS

The Health Care Financing Administration (HCFA) requires that Federally Qualified Health Centers (FQHCs) be reimbursed in compliance with the Benefits Improvement and Protection Act (BIPA) of 2000. Effective January 1, 2001,

Delaware will pay 100% of reasonable cost based on an average of the Fiscal Year 1999 and 2000 audited cost report.

FQHCs are assigned a prospectively determined rate per clinic visit based in actual costs reported on their audited cost reports, and they do not correspond with the Federal Fiscal Year, they would span more than one fiscal year. Starting July 1, 2001, the Medicare Economic Index will be used to inflate their rates. The computation is also adjusted each year to reflect any increase or decrease in the Center's Scope of Services.

The Delaware Medical Assistance Program (DMAP) requires that a new provider submit a cost report so that a rate based on reasonable costs can be established. Any new FQHC~~/RHC~~ will be capped at 100% of the highest rate that Medicaid pays to a FQHC for the initial rate year.

Primary Care costs are separated from Administrative and General costs for purposes of rate calculation. The Administrative and General component is capped at 40% of the highest cost. Each cost component is inflated by the current HCFA Medicare Economic Index.

Medicaid will ensure 100% cost payments regardless of the payment mechanism.

_X_ The rate year for FQHC services is July 1 through June 30.
_X_ The payment methodology for FQHCs will conform to section 702 of the BIPA 2000 legislation.

The payment methodology for FQHCs will conform to the BIPA 2000 requirements Prospective Payment System.

For services provided on or after January 1, 2017 the cost of long-acting reversible contraceptives (LARCs) will be based on actual acquisition cost (AAC). The FQHC must submit a separate claim to be reimbursed for the AAC of a LARC.

20 DE Reg. 523 (01/01/17) (Prop.)