SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

House Legislative Oversight Committee: Planned Parenthood and Abortion

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Federal Oversight of Medicaid

Federal Oversight of Medicaid

- Medicaid was established through 1965 amendments to the Social Security Act (Title XIX).
- Medicaid's governing law has been repeatedly revised ever since, such as through regulation.
- Participating states must each submit a State Plan that meets various federal requirements.
- Failure to comply with federal requirements can lead to a loss of federal Medicaid funding.

Free Choice of Providers

- Federal law states that Medicaid beneficiaries may obtain services from any qualified provider that undertakes to provide the service to them.
  - §1902(a)(23) of the Social Security Act

State plans for medical assistance

(a) Contents

(23) provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services, and (B) an enrollment of an individual eligible for medical assistance in a primary care case-management system (described in section 1396n(b)(1) of this title), a medicaid managed care organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive services under section 1396d(a)(4)(C) of this title, except as provided in subsection (g) of this section, in section 1396n of this title, and in section 1396u–2(a) of this title, except that this paragraph shall not apply in the case of Puerto Rico, the Virgin Islands, and Guam, and except that nothing in this paragraph shall be construed as requiring a State to provide medical assistance for such services furnished by a person or entity convicted of a felony under Federal or State law for an offense which the State agency determines is inconsistent with the best interests of beneficiaries under the State plan or by a provider or supplier to which a moratorium under subsection (kk)(4) is applied during the period of such moratorium;

Free Choice of Providers

- Federal regulations require that each State Plan provide this free choice.
  - 42 CFR 431.51(b)(2)

§ 431.51 Free choice of providers.

(a) *Statutory basis.* This section is based on sections 1902(a)(23), 1902(e)(2), and 1915(a) and (b) and 1932(a)(3) of the Act.

(1) Section 1902(a)(23) of the Act provides that recipients may obtain services from any qualified Medicaid provider that undertakes to provide the services to them.

(b) *State plan requirements.* A State plan, except the plan for Puerto Rico, the Virgin Islands, or Guam, must provide as follows:

(2) A recipient enrolled in a primary care case-management system, a Medicaid MCO, or other similar entity will not be restricted in freedom of choice of providers of family planning services.

Free Choice of Providers

- Free choice explicitly cannot be restricted for family planning services.
  - 42 CFR 431.51(a)(6)

§ 431.51 Free choice of providers.

(a) *Statutory basis.* This section is based on sections 1902(a)(23), 1902(e)(2), and 1915(a) and (b) and 1932(a)(3) of the Act.

(6) Section 1932(a) of the Act permits a State to restrict the freedom of choice required by section 1902(a)(23), under specified circumstances, for all services except family planning services.

Abortion Coverage Under Medicaid

- The State Plan must provide family planning services to women of childbearing age.
  - §Section 1905(a)(4) of the Social Security Act

Definitions

For purposes of this subchapter—

(a) Medical assistance

The term "medical assistance" means payment of part or all of the cost of the following care and services or the care and services themselves, or both (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of medicare cost-sharing with respect to a qualified medicare beneficiary described in subsection (p)(1) of this section, if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title)

(4)(A) nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older; (B) early and periodic screening, diagnostic, and treatment services (as defined in subsection (r) of this section) for individuals who are eligible under the plan and are under the age of 21; (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies; and (D) counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in subsection (bb));

Abortion Coverage Under Medicaid

- Medicaid programs must cover abortions that meet the standard set by the "Hyde Amendment"

SEC. 506. (a) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for any abortion.

(b) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for health benefits coverage that includes coverage of abortion.

(c) The term "health benefits coverage" means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement.

SEC. 507. (a) The limitations established in the preceding section shall not apply to an abortion—

(1) if the pregnancy is the result of an act of rape or incest; or

(2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

(b) Nothing in the preceding section shall be construed as prohibiting the expenditure by a State, locality, entity, or private person of State, local, or private funds (other than a State's or locality's contribution of Medicaid matching funds).

Provider Relationships

Provider Relationships: The Legal Context

- The Department's rights and responsibilities with respect to its providers are scattered across countless documents.
- There are also multiple court decisions to bear in mind.

	Statutory	Regulatory	Administrative
Federal	• Social Security Act • Hyde Amendment	• Code of Federal Regulations	• CMS Informational Bulletin CPI-B 12-02 • Other HHS/CMS guidance
State	• Proviso 33.12 and others	• SC Code of Regulations	• State Plan for Medical Services • Provider Enrollment Manual • Other service manuals • Provider and MCO contracts

Federal Guidelines on Provider Termination

- There are federal laws and regulations that dictate the conditions under which Medicaid providers may be terminated.
  - §1902(a)(39) of the Social Security Act, 42 CFR 455.416

State plans for medical assistance

(a) Contents

(39) provide that the State agency shall exclude any specified individual or entity from participation in the program under the State plan for the period specified by the Secretary, when required by him to do so pursuant to section 1320a–7 of this title or section 1320a–7a of this title, terminate the participation of any individual or entity in such program if (subject to such exceptions as are permitted with respect to exclusion under sections 1320a–7(c)(3)(B) and 1320a–7(d)(3)(B) of this title) participation of such individual or entity is terminated under subchapter XVIII or any other State plan under this subchapter, and provide that no payment may be made under the plan with respect to any item or service furnished by such individual or entity during such period;

§ 455.416 Termination or denial of enrollment.

The State Medicaid agency—

(c) Must deny enrollment or terminate the enrollment of any provider that is terminated on or after January 1, 2011, under title XVIII of the Act or under the Medicaid program or CHIP of any other State.

Federal Guidelines on Provider Termination

- Those regulations have been clarified so as to only apply when the termination is on a "For Cause" basis.
  - CMS Informational Bulletin CPI-B 12-02
- Regardless of the text of our provider enrollment agreement, termination may only be exercised "For Cause."

Examples of For Cause Terminations

1. Providers that are terminated by State Medicaid Agencies as a result of adverse licensure actions, e.g., providers who are reported into the National Practitioner Data Bank (NPDB).
2. Providers that are terminated by State Medicaid Agencies because they have engaged in fraudulent conduct.
3. Providers that are terminated by State Medicaid Agencies due to abuse of billing privileges, e.g., billing for services not rendered or for medically unnecessary services.
4. Providers that are terminated by State Medicaid Agencies due to misuse of their billing number.
5. Providers that are terminated by State Medicaid Agencies due to falsification of information on enrollment application or information submitted to maintain enrollment.
6. Providers that are terminated by State Medicaid Agencies due to continued billing after the suspension or revocation of the provider's medical license.
7. Providers that are terminated by State Medicaid Agencies based on a State and/or Federal exclusion.
8. Providers that are terminated by State Medicaid Agencies due to falsification of medical records which support services billed to Medicaid.

Provider Termination Examples

- Terminations issued by the Department may be appealed.

"For Cause"	Not "For Cause"
• Falsification of information provided on an enrollment application	• Provider relocates to another state
• Continued billing after the suspension or revocation of a license	• Provider voluntarily ends participation
• Failure to provide access to or falsification of medical records	• Provider fails to bill for a certain period of time

Funding for Abortions / Planned Parenthood

Medicaid Funding for Abortion Services

- Family Planning services may be provided on a fee-for-service basis or through a managed care plan.
  - Under federal law, providers may furnish Family Planning services with or without a contract with a managed care plan
- Abortion-related services require a pre-payment review.
  - Providers submit required documentation with claims
- After fiscal year-end, claims are also subjected to post-payment review for "Hyde Amendment" purposes (add'l documentation).

(Data Still Under Review)	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	TOTAL
FFS Beneficiaries	5	7	6	6	4	**28**
FFS $	$20,203	$20,600	$14,127	$23,196	$14,198	**$92,324**
MCO Beneficiaries	36	37	38	31	52	**194**
MCO $	$48,455	$56,585	$35,663	$64,523	$139,811	**$345,037**
Total Beneficiaries:	***41***	***44***	***44***	***37***	***56***	***222***
Total $:	***$68,658***	***$77,185***	***$49,790***	***$87,719***	***$154,009***	***$437,361***

Medicaid's Relationship with Planned Parenthood

- Planned Parenthood South Atlantic is separately enrolled as both a physician group and a pharmacy.
- Affiliated individual practitioners may also bill under their own National Provider Identifier (NPI) numbers, if they are individually enrolled as Medicaid providers.
  - A claim may identify both a "billing provider" and a "rendering provider"
- Total payments to-date for Planned Parenthood in the past five years (FY 2011 through FY 2015) were under $300,000.
  - Includes fee-for-service and managed care
  - Includes cases where PPSA is only the billing provider
- Payments were generally for contraceptive-related services: office visits, pap smears, birth control.

(Data Still Under Review)	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	TOTAL
Fee for Service	$49,225	$25,641	$51,845	$73,942	$27,216	**$227,869**
Managed Care	$16,150	$14,413	$15,787	$15,548	$8,137	**$70,035**
Total:	***$65,376***	***$40,054***	***$67,632***	***$89,490***	***$35,355***	***$297,904***

Important Notes on Data Quality

- The Department has direct control over FFS claims records, but must gather "encounter data" from the MCOs.
  - May take 150 days after data submission to validate data
  - Managed care plans have until October 23rd to meet standards
- Medical home networks have been dissolved and three "new" plans have entered the market.
  - Significant impact on encounter data
- Reporting and analytics tools have changed.
  - Different reports have been used as source data
  - Transitioning away from a proprietary claims standard
- At least one case appears to have spanned fiscal years.
  - There are technical reasons why this can happen, but we are reviewing this case to ensure it's not a double-billing
- Providers may file claims up to one year after the date of service.

Closing Thoughts

DHEC's Recent Actions

- Only one of the entities sanctioned by DHEC this month is enrolled as a Medicaid provider.
  - Enrolled: Planned Parenthood South Atlantic (Columbia)
  - Not Enrolled: Greenville Women's Clinic P.A., Charleston Women's Medical Center
- This week, Planned Parenthood South Atlantic filed a corrective action plan with DHEC and asked the DHEC Board to reconsider four findings.
  - We will continue to monitor this process; may need to determine whether there are any "For Cause" events among any sanctions that are finally enforced

Ongoing Efforts

- Interviewing for our first Chief Compliance Officer.
- Supporting the work of the Office of Attorney General to review Medicaid payments.
- Reviewing the pre-payment review process to confirm policy is being adequately communicated and applied.
- Conducting post-payment reviews under Proviso 33.12.
  - Added Program Integrity staff to increase investigative, analytical capacity
- Issuing a Provider Alert to remind all providers of their obligations to immediately produce records.
- Working with LLR and DHEC to formalize a reporting/notification process for NPDB-reportable events.
- Pressing managed care plans to comply with their contractual obligations to submit timely encounter data.
- Determining whether prior authorizations of certain medications are required.
- Producing records for various investigating agencies and committees.
- Revalidating all enrolled providers by Spring 2016.