Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid, Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

The Family Planning Services Section 1115 Demonstration Waiver allows the State of Mississippi to extend Medicaid eligibility for Family Planning services to all women of childbearing age with incomes at or below one hundred eighty-five percent (185%) of the federal poverty level who would not otherwise qualify for Medicaid. Childbearing age is defined as ages thirteen (13) through forty-four (44). Women who are served in this waiver will be able to secure family planning services through the Mississippi Medicaid program.

A provider's participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, he/she must accept the Medicaid payment in full for those services covered by Medicaid. The provider cannot charge the beneficiary the difference between the usual and customary charge and Medicaid payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then refund the Medicaid payment to the beneficiary. Services not covered under the Medicaid program can be billed directly to the Medicaid beneficiary. DOM does not cover telephone contacts/consultations or missed/cancelled appointments and providers may **not** bill beneficiaries for these services.

The Division of Medicaid program purchases needed health care services for beneficiaries as determined under the provision of the Mississippi Medical Assistance Act. DOM is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers, and for notifications regarding billing, Medicaid policy as it relates to these factors is initiated by DOM.

The Family Planning Waiver limits eligibility to females age thirteen (13) through forty-four (44) who meet the following criteria:

- Individual has a family income at or below one hundred eighty-five percent (185)% of the federal poverty level
- Individual is not pregnant and has not had a medical procedure that would prevent pregnancy, such as tubal ligation or hysterectomy
- Individual is uninsured, and is not enrolled in Medicare, Medicaid, or the State Children's Health Insurance Program (SCHIP)
- Individual is a U.S. citizen or documented immigrant
- Individual is a Mississippi resident

Automatic Eligibility

Women between ages thirteen (13) through forty-four (44) who are eligible for the Medicaid pregnancy program and have reached the end of their sixty (60) day postpartum period will be automatically enrolled in the family planning waiver. A separate application is not required if individual is uninsured. The individual will be notified by mail of eligibility for services.

Individuals eligible for the program will remain eligible for twelve (12) months, or for the duration of the program if less than one (1) year. Recertification will be performed at the end of each year of eligibility. Loss of eligibility will occur only when the one of the following occurs:

- Beneficiary moves from the state of Mississippi
- Beneficiary loses Medicaid eligibility
- Beneficiary becomes eligible for another Medicaid program, Medicare, or obtains health insurance
- Beneficiary requests closure (termination of family planning waiver services)
- Beneficiary has a procedure that prevents pregnancy, such as a hysterectomy or a tubal ligation
- Beneficiary is deceased

Beneficiaries enrolled in the Family Planning Waiver Program receive a YELLOW Medicaid Identification Card. The yellow card signifies that the beneficiary is eligible for family planning waiver services only. Providers are responsible for verification of covered services and beneficiary eligibility. Covered services under the Family Planning Waiver Program are identified on the Division of Medicaid website at http://www.medicaid.ms.gov. Click on Services and Family Planning links. Beneficiary eligibility may be verified by swiping the Medicaid card, calling the Automated Voice Response System (AVRS) of the fiscal agent, or using the Division of Medicaid web portal at http://msmedicaid.acs-inc.com. Refer to Provider Policy Manual Section 3.06 for Verification of Eligibility policy.

Family Planning Waiver Application Form

Women in need of family planning services who are not eligible for another Medicaid program may apply for services under the waiver. The application form may be obtained from a Medicaid eligibility site, a Mississippi State Health Department Clinic or the web site: http://www.medicaid.ms.gov. The applicant must do the following:

- Complete the Application for Family Planning Services; sign and date the form
- Attach a COPY (not original) of the birth certificate (initial application only)
- Attach a COPY (not original) of government issued photo identification such as a driver license or student identification (initial application only)
- Attach a COPY (not original) of the social security card (initial application only)
- Attach a copy of the last paycheck stub(s) for the last month (four weeks) of employment. The stub(s) must be dated no more than one (1) month prior to application. A copy of the paycheck stub(s) must be attached to the application with each renewal. Renewals occur every twelve (12) months.
- Mail the application to the address on the back of the application

Informed Choice

In cases where a Family Planning Waiver applicant is also eligible for Medicaid or State Children's Health Insurance Program (SCHIP), the applicant will be notified and allowed to make an informed choice between the programs.

Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services. Section 1902(a) (23) of the Social Security Act provides that "any individual eligible for medical assistance (including drugs) may obtain such assistance from institution, agency, community pharmacy, or person qualified to perform the service or services required."

Participants in the family planning waiver have the right to freedom of choice for the following:

- Providers of waiver covered services
- Family planning methods

Family planning waiver services are services provided to eligible beneficiaries who voluntarily choose to prevent pregnancy, plan the number of pregnancies, or plan the spacing between pregnancies.

Family planning waiver services are provided, with limitations, in the following general categories:

- Visits
- Contraceptive drugs
- Contraceptive devices
- Voluntary sterilization
- Laboratory procedures

Visits

Visits must be for the purpose of family planning. Counseling and education are considered part of the family planning visit and may not be billed separately. Providers must bill using the Evaluation and Management CPT Code appropriate for the level of service.

- The initial visit is the first time a beneficiary receives family planning services. This visit includes the establishment of medical records, an in-depth evaluation including a medical history, a complete physical exam, establishment of baseline laboratory data, contraceptive and sexually transmitted disease prevention counseling, issuance of supplies or prescription, and family planning counseling and education.
- The annual visit is the re-evaluation of an established patient. These visits include an update to medical records, interim history, complete physical examination, appropriate diagnostic lab tests or procedures, and family planning management, education and counseling.
- The periodic revisit is a follow-up evaluation of an established patient with a new or existing family planning condition. These visits are for evaluation of a new contraceptive, contraceptive changes or contraceptive problems (such as break-through bleeding).
- Office visits are limited to four (4) annually.

Contraceptive Drugs

- Prescription contraceptives, such as oral contraceptive agents, topical patches, self inserted contraceptive products or injectable contraceptives, are available through the pharmacy program. Beneficiaries enrolled in the Family Planning Waiver are eligible for Medicaid coverage of family planning services only and are not eligible for other Medicaid pharmacy services.

- Contraceptive injections administered in the provider's office are covered.
- Prescription contraceptives are available through private providers enrolled in the Mississippi State Department of Health's family planning program.

Contraceptive Devices

- Insertion and removal of contraceptive intrauterine devices are covered. The device must be billed as a separate charge.
- Insertion and removal of contraceptive implants are covered. The implant must be billed as a separate charge.
- Diaphragm or cervical cap fitting with instruction is covered. The device may not be billed as a separate charge.
- Vaginal rings are covered.

Voluntary Sterilization

Tubal ligation procedures, including tubal ligation by hysteroscopy, are covered if they meet Medicaid criteria for sterilization. Refer to Provider Policy Manual Section 25.29 for Sterilization policy

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In the event a second sterilization procedure is required due to failure of the first procedure, coverage for a second covered procedure will be provided. A second sterilization consent form must be completed. Documentation in the beneficiary's medical record must include the date of the first sterilization and the reason for the procedure failure. Refer to Provider Policy Manuals Section 53.19 for Failed Sterilization Procedures policy.

Laboratory Procedures (Initial and Annual Visits)

Laboratory procedures that must be conducted during initial and annual visits include the following:

- Complete blood count
- Urinalysis
- PAP smear
- STD/HIV test
- Pregnancy test, as indicated

A list of laboratory services and codes may be found on the Division of Medicaid website at http://www.medicaid.ms.gov. Click on Services and Family Planning links.

Non-Covered Services

Certain services are not considered family planning services and are not reimbursable under the waiver program. These include, but are not limited to, the following:

- Facilitating services such as transportation
- Infertility studies, procedures to enhance fertility including reversal of sterilization, artificial or intrauterine insemination or in-vitro fertilization
- Sterilization by hysterectomy
- Therapeutic abortion or any related services
- Spontaneous, missed or septic abortions and related services
- Inpatient hospital visit
- All services provided for the treatment of a medical condition including a medical complication of a family planning service
- Removal of an intrauterine device (IUD) because the beneficiary has a uterine or pelvic infection
- Emergency contraceptives and related services
- Over-the counter contraceptive devices such as condoms, spermicidal and sponges are not covered
- Prescriptions other than contraceptives

Codes

A complete list of covered family planning diagnosis codes and procedure codes may be found by accessing the Division of Medicaid website at http://www.medicaid.ms.gov. Click on Services and Family Planning links.

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The Quality Assurance Plan consists of quality assurance activities designed to:

- Ensure the provision of comprehensive, accessible, quality and appropriate services
- Provide a system for accountability and measuring performance
- Improve care outcomes and quality of life

Activities/functions will be performed by Division of Medicaid program staff in conjunction with the Mississippi State Department of Health quality monitoring and quality improvement activities for their clinics.

- Ensure standards of care for family planning waiver services are evidence based best practices
- Conduct periodic on site review of medical records

The Division of Medicaid (DOM) has implemented a process for periodic on-site review of medical records to determine that participants have received appropriate medical care and are appropriately referred for needed primary care. Providers selected for review are determined through random selection. In order to be eligible for review, the provider must have seen a minimum of twenty-five (25) family planning enrollees during the past year. No less than ten percent (10%) i.e., a minimum of fifteen (15) and a maximum of thirty-five (35), of a provider's medical records are reviewed by a Medicaid Program Nurse.

Program areas that may require a written plan of correction and/or a follow-up review include: medical documentation, health education, primary care referral, lab, and contraceptive choices. Medical record compliance and plan of correction necessity for the on-site reviews are as follows:

- 97% and above-no written plan of correction necessary
- 91% to 97%-written plan of correction, but no follow-up review
- 90.9% and below-written plan of correction and a six (6) month follow-up review

At the conclusion of the site visit, the Medicaid Program Nurse will conduct an exit interview with the appropriate staff. The findings of the review will be discussed. Written findings will include both strengths and weaknesses and will be submitted to the provider within fourteen (14) days of the completion date of the review. Effective with the waiver renewal period, it will be required that reviews of medical records include at least five (5) cases where the family planning enrollee is less than twenty (20) years old in order to review a cross-section of teens.

DOM will develop instruments for evaluation of participant and provider satisfaction with the care and services provided and the overall family planning program. These surveys will assist the Division of Medicaid with assessing whether family planning services are available, accessible and appropriate; whether the participants are satisfied with the services received; and, whether the participants are referred for primary care when needed. These surveys should also assist in developing strategies for improving the program as well as identifying barriers to the success of the program.

DOM will perform tracking and trending analyses of complaints and appeals. When indicated, the information obtained will be integrated into quality improvement activities.

Section 1902(a) (14) of the Social Security Act permits states to require certain beneficiaries to share some of the costs of receiving Medicaid services.

Family planning services are exempt from cost sharing (co-pay) requirements. Claims must be filed with the appropriate exception code as indicated on the claim in the beneficiary ID field as suffix to the Medicaid number. Otherwise, co-payment will be deducted from the claim payment amount.

Example: 123456789F

Example: 999999999F

Health concerns not covered by the family planning waiver may be identified during a family planning visit and require follow-up by a primary care provider. Providers of family planning waiver services must be prepared to make necessary clinical referrals. Whenever possible, beneficiaries should be referred to Federally Qualified Health Centers (FQHCs), Community Health Centers, or Rural Health Clinics. This is an important component of the family planning waiver program. Primary care referrals should be documented in the beneficiary's medical record. Referrals are a component of the medical record audits.

All professional and institutional providers participating in the Medicaid program are required to maintain legible, accurate, and complete records that disclose and justify the services rendered and billed under the program and, upon request, make these records available to representatives of DOM in substantiation of all claims. These records must be maintained a minimum of five (5) years to comply with all state and federal regulations and laws.

In order for DOM to fulfill its obligation to verify services rendered to Medicaid beneficiaries and those paid for by Medicaid, the provider must maintain auditable records that will substantiate the claim submitted to Medicaid. At a minimum, Family Planning documentation must include the following on each beneficiary:

- Date of service
- Reason for visit
- Physical findings including vital signs and weight
- Treatments/procedures rendered
- Demographic information (name, address, Medicaid number, date of birth, sex, marital status)
- Allergies
- Medical history (past and present) that is updated annually. The history must include social history (smoking, alcohol, and activity), sexual history (age of onset, partners, etc), and obstetrical and gynecological history.
- Family history
- Tests and their results
- Medications-documentation must reflect all drugs, including contraceptives, whether administered by the provider, prescribed, or issued via samples, etc. Documentation must include the name of medication, strength, dose, and route. The method of administration and site must be included for all injectable medications. Documentation must reflect whether prescriptions were issued in writing or by telephone.
- Contraceptive supplies-record all drugs, including contraceptives, whether administered by the provider, prescribed, or issued via samples, etc.
- Contraceptive devices
- Contraception counseling
- Date, time, and signature for all entries in the beneficiary record
- Provider orders-include time, date, and signature for all medications, treatments and procedures rendered

- Consents for treatment, as applicable

Refer to Provider Policy Manual Section 7.03 for additional Maintenance of Records policy.

If the provider's records do not substantiate services paid for under the Mississippi Medicaid program, as previously noted, the provider will be asked to refund to DOM any money received from the Medicaid program for such non-substantiated services. If a refund is not received within thirty (30) days, a sum equal to the amount paid for such services will be deducted from any future payments that are deemed to be due the provider.

A provider who knowingly or willfully makes or causes to be made, a false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws. A false attestation can result in civil monetary penalties, as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.