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September 15, 2014

Submitted electronically via: <http://www2.illinois.gov>

Illinois Department of Healthcare and Family Services  
401 South Clinton  
Chicago, Illinois 60607

**RE: Comments regarding Illinois Family Planning Action Plan**

Dear Madame/Sir:

Thank you for the opportunity to provide comments on the draft Illinois Family Planning Action Plan. We welcome the initiative and strongly support your Department's goal of increasing access to family planning services for women and men in the Medicaid program by providing comprehensive and continuous coverage to ensure that individuals are able to plan their pregnancies.

The National Health Law Program (NHeLP) is a public interest law firm working to protect health rights and advance access to comprehensive, quality health care for low-income and underserved people. The oldest non-profit of its kind, NHeLP advocates, educates, and litigates at the federal and state levels. Consistent with this mission, NHeLP supports policies that seek to ensure that all individuals have the means, information, and opportunity to make their own decisions about when and whether to become a parent.

**Comments in response to Action #1**

NHeLP supports the draft Action Plan's proposals to double reimbursement rates for intrauterine devices (IUDs) and vasectomies. We also applaud the proposed policy to permit reimbursement for two services on the same day when long-acting reversible contraceptives (LARC) are provided in the context of an initial or established annual exam or problem visit. These policies will increase timely access to the full range of contraceptive options, promote contraceptive equity between men and women, and prevent enrollees from delaying care and enduring multiple visits to receive the contraceptive services to

which they are entitled. In addition, this policy is cost-effective because it will eliminate unnecessary repeat provider visits.

We also support the increase to 340B providers' dispensing fees for LARC and all hormonal contraceptives and urge the Department to extend the increase beyond 340B providers to all family planning providers. Additionally, we ask the Department to consider increasing the three-month supply requirement to require – or at a minimum, allow – a full year's supply of oral contraceptive pills, the patch, or the ring to be dispensed at once. This recommendation is in line with *Providing Quality Family Planning Services: Recommendations of the CDC and the U.S. Office of Population Affairs*, which recommends that providers provide or prescribe a full year's supply "to minimize the number of times a client has to return to the service site."<sup>1</sup>

We also appreciate the Department's commitment to investigate a change in payment policy to allow hospitals to bill for LARC insertion immediately postpartum. According to evidence-based guidelines and standards of care, IUDs and implants can be safely inserted immediately postpartum in almost all instances.<sup>2</sup> Women who choose a LARC method and would like to have it inserted immediately postpartum should not be forced to wait and return to their provider at a later date due solely to payment policies that prohibit reimbursement at the time of childbirth. Such delays in care increase the risk of unintended rapid repeat pregnancies and associated health risks, and fall hardest on low-income women who may be unable to attend multiple appointments due to barriers such as lack of sick leave, childcare, or transportation. We therefore urge the Department to go beyond *investigation* and join states including South Carolina, New York, Colorado, and New Mexico in *implementing* reimbursement policies that facilitate immediate postpartum LARC insertion.

## **Comments in response to Action #2**

NHeLP applauds the Department's commitment to ensuring that Medicaid enrollees receive evidence-based counseling and education on all FDA-approved contraceptive methods. While we appreciate the reasoning and evidence base behind counseling on methods in order of most-effective to least-effective, we ask the Department to recognize the long history of coercion of women's contraceptive decisions and continue to emphasize to health plans and providers the importance of patient choice in the context of contraceptive care. Standards of care require that women have access to a wide range of contraceptive brands, formulations, and delivery systems. Choosing the most appropriate method is a complex and individualized process that cannot be determined apart from a woman's medical history, preferences and concerns, reproductive goals, and interpersonal relationships.

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<sup>1</sup> Centers for Disease Control and Prevention, *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs*, MMWR 2014;63 (No. RR-4), 11.

<sup>2</sup> Centers for Disease Control and Prevention, *U.S. Selected Practice Recommendations for Contraceptive Use*, MMWR 2013;62 (No. RR-5).

We further recommend that the Department add accountability and enforcement measures to ensure that plans are reimbursing for and providers are delivering age-appropriate sexuality education and reproductive health education as part of regularly mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) health screens for youth. A recent CMS report, *Paving the Road to Good Health: Strategies for Increasing Medicaid Adolescent Well-Care Visits*, recommends that states align their EPSDT policies with the American Academy of Pediatrics' *Bright Futures: Guidelines for Child Health Supervision of Infants, Children, and Adolescents* (Bright Futures).<sup>3</sup> *Bright Futures* recommends that physicians provide "confidential, culturally sensitive and nonjudgmental" sexuality education and counseling to children, adolescents, and their caretakers.<sup>4</sup> Education and counseling have been shown to increase contraception use, reduce the adolescent pregnancy rate and increase knowledge regarding sexual health.

We strongly support the proposal to communicate to all health plans and providers that cost sharing, step therapy failure requirements, and prior authorization are never acceptable in the provision of family planning services. Medical management techniques that limit or delay a woman's access to her preferred method not only deny women control of their reproductive autonomy, they also lead to lapsed or inconsistent contraceptive use and increased risk of unintended pregnancy.

We support the Department in requiring health plans to submit their family planning policies annually. We particularly appreciate the requirement that plans report on their referral policies if they object to covering contraception. We recommend that the State not contract with plans that *refuse* to make *referrals* for family planning; however, if it chooses to do so, the Department must be aware of those policies and provide individual enrollees with information directly about how to access covered services outside of their plan. We also urge the Department to require plans to provide clear information to current and prospective enrollees about any services and referrals to services that are not available due to plan objections, and we ask the Department to make plans' family planning policy information publicly available. Medicaid enrollees are entitled to freedom of choice for family planning services and supplies, and it is critical that all enrollees have clear information about how to access those services when the plan they are enrolled in refuses to cover them.

We further recommend that the State require, as part of the annual reporting, that plans detail their policies for ensuring that individuals have access to family planning services when a participating *provider* refuses to make a referral for services to which s/he has an objection. The refusal of a primary care provider to make a referral can become a significant obstacle to services. Every plan should have a procedure to override the provider objection, and ensure the enrollee is able to access the services s/he needs.

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<sup>3</sup> CMS, *Paving the Road to Good Health: Strategies for Increasing Medicaid Adolescent Well-Care Visits* 8-28 (Feb. 2014).

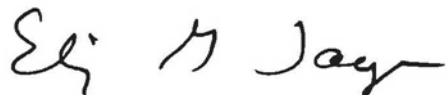
<sup>4</sup> Am. Acad. of Pediatrics, *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* 174 (2008).

Finally, we appreciate the Department's willingness to continue partnering with providers, advocates, and the pharmaceutical industry to ensure that Medicaid providers have LARC inventory available for same-day insertion. The financial infeasibility of stocking these high-cost devices is a significant problem for many providers and leads to unnecessary delays in contraceptive access. While we agree that pharmaceutical companies could and should do more, we also believe the Department has a role to play in ensuring that providers can maintain a ready stock for patients. We encourage consideration of innovative policy solutions, including those suggested by the Section of Family Planning and Contraceptive Research at the University of Chicago in their comments on the draft Action Plan:

- The Department could purchase LARC devices and distribute them to clinics based on reported clinic volume. Providers could then submit claims for patients who receive the device and insertion costs, but not receive additional reimbursement for the device.
- The Department could add the option of direct pharmacy dispensing once again and allow providers to place LARC devices in other Medicaid-enrolled patients if the original patient does not return for her appointment and is lost to follow-up.

We appreciate the opportunity to provide comments and thank you for your leadership and demonstrated commitment to improving access to family planning for individuals enrolled in your state's Medicaid program. If you have any questions, please feel free to contact NHeLP staff attorney Erin Armstrong at [Armstrong@healthlaw.org](mailto:Armstrong@healthlaw.org).

Sincerely,

A handwritten signature in black ink that reads "Elizabeth G. Taylor". The signature is written in a cursive, flowing style.

Elizabeth G. Taylor  
Executive Director