State of California—Health and Human Services Agency

Department of Health Services

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MMCD All Plan Letter 03010

TO: County Organized Health System Plan (COHS)
Geographic Managed Care (GMC) Plans
Two-Plan Model Plans

FROM: Luis R. Rico, Acting Chief
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SUBJECT: MEDI-CAL MANAGED CARE PLAN REQUIREMENTS FOR PROVISION OF CONTRACEPTIVE DRUGS, DEVICES AND SUPPLIES

Purpose:

The purpose of this All Plan Letter is to inform Medi-Cal managed care plans that Department of Health Services' (DHS) contractual requirements and Medi-Cal Managed Care Division (MMCD) family planning policy letters do not require plans to provide all Federal Food and Drug Administration (FDA) approved contraceptive drugs, devices and supplies (contraceptives) to members without prior authorization. Plans may elect to provide some contraceptives through a prior authorization process, as long as the requirements stated in the discussion below continue to be met.

Background:

The scope of family planning drug coverage is included in the California Code of Regulations, Title 22, Section 53854(d) which states: "Except for drugs specifically excluded from the contract, any drug covered by the Medi-Cal Program shall be available from the plan when determined to be medically necessary. This shall not be construed to require a plan to include in its formulary every drug listed on the Medi-Cal formulary or to prevent a plan from performing appropriate utilization review to determine the most suitable drug therapy for a particular medical condition…."

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Federal regulation [42 CFR 438.210(a)(2)] further describes requirements regarding, among other services, the scope of family planning drug coverage, by stating:

> "Each contract with an MCO (Managed Care Organization), PIHP (Prepaid Inpatient Health Plan), or PAHP (Prepaid Ambulatory Health Plan) must do the following: (2) Require that the services…be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in §440.230."

In addition, California Assembly Bill 39, Chapter #532, Statutes of 1999 in Section 2(1) added Section 1367.25 to the Health and Safety Code, which states in part:

> "A health care service plan contract that provides coverage for outpatient prescription drug benefits shall include coverage for a variety of federal FDA approved prescription contraceptive methods designated by the plan. In the event the patient's participating provider, acting within his or her scope of practice, determines that none of the methods designated by the plan is medically appropriate for the patient's medical or personal history, the plan shall also provide coverage for another federal FDA approved, medically appropriate prescription contraceptive method prescribed by the patient's provider."

These citations form the basis of DHS policy regarding the provision of contraceptive drugs, devices or supplies by Medi-Cal managed care plans.

Discussion:

Contraceptive drugs, devices and supplies exist in many FDA approved formulations, strengths, types and routes of administration and are produced by many manufacturers, with new forms appearing frequently. Plans may elect to provide FDA approved contraceptives to members with or without prior authorization. If a plan elects to provide some contraceptives through a prior authorization process, plan written procedures must continue to ensure that:

- Members have access to a variety of FDA approved prescription contraceptive drugs, devices and supplies, without prior authorization;

- Formulary lists that include all prescription contraceptive products that are available to members without prior authorization are provided to plan network providers, with updates made available as necessary;

- Prior authorization procedures are clearly described to plan network providers. Prior authorization procedures should clearly describe the process for requesting a contraceptive determined to be medically necessary and subject to prior authorization;

- Plan prior authorization procedures shall not cause delay in either provision of the contraceptive to the member or reimbursement to any provider of family planning pharmacy services, including out-of-plan providers, in accordance with MMCD family planning Policy Letter 98-11 instructions, using current Medi-Cal fee-for-service reimbursement rates. Welfare and Institutions Code, Section 14185, requires plans to provide "a response within 24 hours or one business day to a request for prior authorization made by telephone or other telecommunication device";

- To the extent possible, plans should provide identified out-of-plan family planning providers with the plan formulary list of contraceptive products available without prior authorization and inform these providers of plan prior authorization procedures;

- A Medi-Cal beneficiary who is on a particular contraceptive drug, device or supply when she enrolls in a managed care plan, shall continue to be maintained on this same drug, device or supply until a plan provider has determined that another form of contraceptive product of equal therapeutic efficacy can be substituted and this proposed change is discussed with the member.

If you have any question regarding this All Plan Letter, please contact
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