

Making Medicaid Managed Care Work for Family Planning Coverage and Services

By Adam Sonfield

The year 2014 was the first year of the Affordable Care Act's (ACA's) broad expansion of Medicaid to individuals up to 138% of the federal poverty level. Despite the fact that 22 states have yet to agree to the expansion, Medicaid enrollment has surged. By December 2014, 70 million individuals—about one in five Americans—were enrolled in Medicaid or its sister program, the Children's Health Insurance Program, an increase of 11 million from mid-2013.¹

By the ACA's design, almost all of these new Medicaid enrollees are receiving their coverage through health plans run not by the state but rather by private-sector managed care organizations (MCOs). And well before the ACA was implemented, most Medicaid enrollees—including most low-income women and men of reproductive age enrolled in the program—were in some form of managed care, making privately run MCOs integral partners in most states' Medicaid programs.²

One year into the ACA's Medicaid expansion, it is well past time for revisions to federal regulations for Medicaid managed care. Current regulations largely date back to 2002, when the Bush administration overhauled them in response to the Balanced Budget Act of 1997, which gave states the option to implement Medicaid managed care without special permission from the federal government. The Centers for Medicare and Medicaid Services (CMS) has announced that it will propose sweeping changes to these regulations in 2015 in response to the ACA and to numerous indications, including several inspector general reports, that enrollee protections under Medicaid MCOs are not working as intended.

HIGHLIGHTS

- *Medicaid enrollment is 70 million and rising rapidly, and the program relies increasingly on partnerships with privately run managed care organizations.*
- *Family planning is a small part of Medicaid, but Medicaid is central to publicly funded family planning—so, federal rules for Medicaid managed care have great potential to improve or hinder family planning care for millions of low-income Americans.*
- *The Centers for Medicare and Medicaid Services should strengthen, monitor and enforce protections for Medicaid managed care enrollees related to coverage and cost-sharing, confidentiality, choice of providers, and access to information and care.*

CMS's decisions could have major implications for family planning services under Medicaid. Even before the ACA's expansion, in 2013, 17% of women aged 15–44 were enrolled in Medicaid, including 43% of those below the poverty level (see chart, page 9).³ At latest count, the program accounted for three-quarters of public family planning dollars and funded half of all U.S. births, including two-thirds of unplanned births.^{4,5} As Medicaid enrollment continues to expand, those numbers seem all but certain to continue to rise.

In revising its rules for Medicaid MCOs, CMS could help or hinder access to and use of family planning services and providers in numerous ways. In this light, reproductive health professionals and advocates—including the American Congress of Obstetricians and Gynecologists, the Guttmacher Institute, the National Family Planning and Reproductive Health Association, the National

Health Law Program, the National Women’s Law Center and Planned Parenthood Federation of America—have pressed the agency to clarify Medicaid’s guarantees for reproductive health coverage, bolster its protections for patient confidentiality, ensure enrollees’ access to qualified providers and attain the delicate balance between protecting patients’ health and respecting religious objections by plans and providers.^{6,7}

Coverage and Cost-Sharing

One reason Medicaid is so important to family planning is that for decades, the program has included strong protections for the coverage of these services. Since the early years of the program, federal law has required states to cover family planning services, and to do so without any copayments or other patient cost-sharing. Congress and CMS have maintained these protections even as they have shifted Medicaid toward a managed care model, which is predicated on attempts to curb health care spending through tactics such as coverage limits and patient cost-sharing. And in some ways, the ACA has expanded these protections under Medicaid: People newly eligible for Medicaid because of the ACA’s expansion are enrolled in so-called Alternative Benefit Plans (ABPs), which are designed to mirror private-sector health plans. And just like most private-sector health plans, these ABPs must comply with the ACA’s requirement to cover a wide array of recommended preventive services without cost-sharing. That array of protected services includes contraceptive methods, services and counseling; STI and cervical cancer tests; human papillomavirus (HPV) vaccination; and many others (see “Beyond Contraception: The Overlooked Reproductive Health Benefits of Health Reform’s Preventive Services Requirement,” Fall 2012).

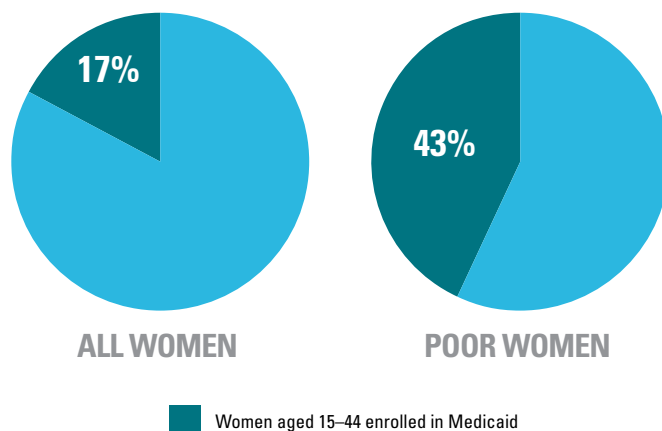
Despite these long-standing protections, gaps in coverage persist. Federal rules do not generally specify what constitutes family planning services under Medicaid, and that allows for state-level variability in what is covered. Medicaid managed care compounds that variability, because unless the state is specific in its contract terms, MCOs have flexibility as well. Therefore, it should be no surprise that state Medicaid programs do not universally cover the full range of services.^{8,9}

Moreover, multiple studies have indicated that Medicaid plans are sometimes assessing cost-sharing for contraception, contrary to federal law. Most recently, a 2013 Guttmacher Institute study found that about one-fifth of women with public insurance—the vast majority of whom would be Medicaid enrollees—reported paying some amount out of pocket for oral contraceptives.¹⁰ In addition, anecdotal reports indicate that MCOs are sometimes imposing other types of coverage restrictions to control costs, particularly for contraceptive methods with high up-front costs, such as IUDs or implants.¹¹ These restrictions include inappropriate quantity limits (such as denying coverage for a second IUD if the first one dislodges), requiring a clinician to obtain prior authorization before providing certain methods and requiring women to try one or more oral contraceptives before covering a more expensive method (so-called step therapy). These problems were notable enough that officials in Illinois changed their managed care contracts in 2014 to ban cost-sharing, prior authorization and step-therapy for family planning services.¹²

CMS should exercise its authority to address all of these issues by reiterating and reinforcing the rights of Medicaid enrollees in MCOs. Specifically, Medicaid’s coverage of family planning methods and services should be equal across Medicaid

MEDICAID MATTERS

Seventeen percent of U.S. women of reproductive age were enrolled in Medicaid in 2013, including 43% of poor women.



Source: Current Population Survey.

populations. This could be accomplished in part by setting the ACA's preventive services requirement as a floor for all Medicaid plans, not just ABPs—something the Obama administration proposed to do in its 2016 federal budget. Among other things, that would mean requiring plans to cover the full range of Food and Drug Administration–approved contraceptive methods without cost-sharing.¹³ Similarly, states and MCOs should be required to cover the full range of family planning services; as a guide, they could use the 2014 standards developed by the Centers for Disease Control and Prevention and the Office of Population Affairs.¹⁴ CMS should also follow Illinois's lead in requiring MCO contracts to specify that cost-sharing is prohibited for family planning care, and in banning coverage restrictions that lack a clinical evidence base, such as inappropriate coverage limits, prior authorization and step therapy. Finally, appropriate oversight and enforcement of these enrollee protections is a vital role for states, with the federal government as a backstop to ensure that states are following through.

Patient Confidentiality

Confidential access to family planning and to other sensitive care has long been supported by public health experts, so that potential patients do not shy away from seeking care out of fear that a parent, spouse or sexual partner may find out. That is particularly important not only for teenagers but also, for example, for victims of domestic abuse.

Nonetheless, confidentiality can be difficult to maintain, particularly once MCOs enter the picture. For example, enrollees' confidentiality is often breached inadvertently by health plans through explanation of benefits letters and other communications about services, billing and benefits (see "A New Frontier in the Era of Health Reform: Protecting Confidentiality for Individuals Insured as Dependents," Fall 2013). Furthermore, the systems set up by states and MCOs to provide alternate modes of communication about coverage and services may not mesh with other well-intentioned systems. For instance, confidentiality could be accidentally breached when a state attempts to ease enrollment and renewal using information about enrollment in other state assistance programs. And privacy protections

for enrollees could interfere with their ability to dispute denials of coverage, particularly if most communication with a state agency or an MCO is routed through another family member who is considered head of the household.

Revisions to the Medicaid managed care regulations provide a welcome opportunity to bolster Medicaid's confidentiality protections. States should be required to establish, monitor and enforce MCO requirements regarding the treatment of confidential information about service utilization, paying attention not only to the standards plans must meet, but also to the systems they establish to meet those standards. CMS should also query states about potential points of confusion about interpreting federal rules, and provide them with greater clarity and technical assistance when needed.

Access to Providers

Strong protections for coverage and confidentiality must be paired with ready access to qualified providers, and Medicaid has a wide array of protections to that effect. These protections, however, are not strong enough, nor adequately monitored and enforced.

Network Adequacy

Current Medicaid regulations require plans to maintain a network of providers sufficient to meet the health care needs of enrollees, and to reimburse those providers well enough to achieve that goal. However, such network adequacy requirements provide little in the way of protections specific to family planning providers, and that shows. As of 2010, only 40% of safety-net health centers providing family planning services had any contracts with Medicaid plans.¹⁵ Beyond family planning, there is wide variety in states' actual network adequacy standards (including, in some states, no standards at all specific to key providers, such as obstetricians) and little oversight or enforcement, according to an inspector general report from September 2014.¹⁶ A second report from December 2014 found serious problems on the ground with provider availability, including inaccurate provider directories, large numbers of providers not accepting new patients and long waiting times for appointments, especially for specialists.¹⁷

To address these problems, plans must be required to meet strong network adequacy standards for all providers. That should specifically include safety-net family planning providers and obstetrician-gynecologists, to ensure that enrollees have meaningful and timely access to these services. As part of this, CMS should step up its standards, oversight and enforcement of the requirement that states and plans pay rates that are sufficient to achieve network adequacy.

One model to strengthen network adequacy can be found in the ACA's requirements for private health plans offering coverage on the new marketplaces: Those plans must contract with so-called essential community providers—specified types of safety-net providers, including family planning centers, that serve low-income patients (see “Vigilance Needed to Make Health Reform Work for ‘Essential Community Providers,’” Spring 2013). These requirements should be adopted and incorporated into the regulations for Medicaid managed care. And because these safety-net providers are central to serving Medicaid enrollees, these standards should be stronger than those that apply in the private sector.

Freedom of Choice

By contrast, Medicaid does have particularly strong protections to ensure access to family planning providers out of network. States that choose to contract with MCOs for their Medicaid program are generally allowed to limit enrollees' coverage to in-network providers to control spending. However, federal law includes an exception that allows Medicaid enrollees to go outside of a plan network to obtain family planning services and supplies from the Medicaid-participating provider of their choice.

Implementing this protection, however, has never been easy. Because freedom of choice is allowed for only a limited package of services, this can cause difficulties for patients and clinicians: For example, a clinician may be reimbursed for diagnosing an STI, but not for providing treatment following diagnosis.¹⁸ In addition, systems in which providers attempt to obtain reimbursement from an MCO—rather than directly from the state—can result in a lack of timely and adequate payment.

And enrollees might not be adequately informed or aware of their right to go out of network to obtain care.

These protections should be reiterated and strengthened by requiring that states and plans inform enrollees of these rights on a recurring basis, in consumer-friendly language. In addition, states and plans should be required to ensure that health care providers delivering family planning services out of network are appropriately reimbursed in a timely manner. CMS should clarify that the full scope of family planning methods, services and counseling—and follow-up care, when needed—is covered.

Nondiscrimination Protections

One additional issue related to access to providers has been attempts by certain states and health plans to exclude or otherwise discriminate against providers based on the scope of services they deliver, such as family planning providers that also offer or refer patients for abortion care. In 2011 and 2012, Arizona and Indiana attempted to exclude some specialized family planning providers from participating in Medicaid. Each time, CMS pushed back, making it clear that this was counter to federal law and sending a 2011 letter to all state Medicaid agencies reminding them that they may not “exclude providers from the program solely on the basis of the range of medical services they provide” and that “Medicaid programs may not exclude qualified health care providers—whether an individual provider, a physician group, an outpatient clinic, or a hospital—from providing services under the program because they separately provide abortion services...as part of their scope of practice.”¹⁹ Federal courts have concurred.

The revisions to the Medicaid managed care regulations provide an opportunity for CMS to incorporate and reinforce this nondiscrimination standard, and to make it clear that it applies both to states and MCOs. Moreover, it should be made clear that excluding a provider entirely is not the only prohibited form of discrimination: States and plans may not impose other discriminatory terms—such as inferior reimbursement—on providers' participation in Medicaid and MCO networks.

Religious Exemptions

Federal Medicaid law does not require providers to offer all services, or MCOs to cover all services. The Balanced Budget Act of 1997 made it clear that an MCO is even allowed to refuse to provide coverage for counseling and referral related to specific services, if it objects on religious or moral grounds. At the same time, federal law and regulations place an obligation on states to ensure that enrollees have coverage for all Medicaid services—even if some services are carved out of an MCO contract or are unavailable in an MCO’s provider network—and that enrollees know about their rights and how to access needed care.

Current Medicaid regulations attempt to balance the rights of MCOs and providers with the obligation to connect enrollees to information and care. Enrollees may leave a Medicaid plan at any time if, because of religious or moral objections, it does not cover services that the enrollee needs. They may also go out of network at any time for family planning care, under the freedom of choice provision. Even if a plan objects to paying for certain types of counseling or referral, it may not block providers from advising or advocating on behalf of their patients (although without compensation). Plans must generally tell enrollees and potential enrollees about Medicaid-covered services that the plan itself does not cover, including how and where the enrollee may obtain those benefits. For counseling and referral services to which a plan objects on religious or moral grounds, the plan must only inform enrollees, potential enrollees and the state of its decision; providing enrollees with information about how to access those services is the state’s obligation.

Collectively, those rules are complex, particularly for enrollees, and it is not clear that they are working well in practice. States’ responsibility for ensuring that enrollees have access to the full range of covered sexual and reproductive health information, referrals, services and providers should be clarified and strengthened. One option would be for states to establish a toll-free hotline and an online portal through which enrollees could learn how and where to obtain needed care not covered by plans, and to require plans and providers to direct patients to those resources when needed.

Plans, too, should be reminded of their obligation to ensure enrollees’ access to all services under their contract, even when clinicians and facilities in their network have their own religious or moral objections. And states and plans should be required to inform enrollees of their rights on a recurring basis, and to ensure appropriate oversight and enforcement.

Vital Program, Vital Protections

Federal regulations governing Medicaid managed care have an ever-widening reach. Medicaid is already a vital component in the U.S. health care system, focusing its resources on the low-income individuals and families most in need of coverage. The program is already intimately tied to private-sector MCOs, and that connection will only grow stronger as the ACA is fully implemented. Moreover, any rules established by CMS for Medicaid can have a broader influence, because many MCOs are now operating across a wide array of markets, including employer-sponsored coverage, subsidized marketplace plans, Medicaid and Medicare.

For these reasons, it is essential that any new rules get these protections right for Medicaid enrollees and the safety-net providers who serve them. And it is equally important that enrollees know about these protections, and that states and plans comply with them. Family planning is a relatively small component of Medicaid, but Medicaid is a driving force for family planning. So, as CMS works to improve Medicaid in the era of the ACA, it must pay attention to the details that could result in meaningful improvements in the provision of family planning care for millions of Americans. ■

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