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Medicaid Managed Care and Women's Health

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Key Resources

NHeLP Issue Brief: Medicaid Managed Care and Women's Health (August 2013), available here.

NHeLP Issue Brief: Managed Care Informing and Disclosure Requirements (August 2012), available here.

NHeLP Fact Sheet: Medicaid Managed Care: Enrollment and Education (April 2012), available here.

NHeLP Issue Brief: Accountability and Stewardship in Medicaid Managed Care (June 2007), available here.

Coming in September's Health Advocate:

Everything you need to know about Open Enrollment

Overview

Over the past 30 years, managed care has come to dominate the Medicaid health care delivery system. By 2010, two-thirds of Medicaid enrollees received most of their services through some form of managed care, which includes risk-based, capitated plans and primary care case management systems. At all ages, women make up the majority of beneficiaries receiving Medicaid. It is therefore no surprise that the majority of low-income women and children enrolled in Medicaid now obtain their care through managed care.

Studies have shown that risk-based managed care can add barriers to care for women. Many of the problems that were noted in a 1998 study by the Center for Women Policy Studies still exist today: lack of confidentiality, lack of formal referral structures to appropriate providers, lack of appropriate quality measures and standards, and lack of transparency in providing plan information, including benefit availability.

As implementation of the Affordable Care Act (ACA) proceeds, reliance on Medicaid managed care is expected to grow. Accordingly, this issue of the Health Advocate identifies some of the key considerations for serving low-income women of all ages in these managed care systems.

Introduction to Medicaid Managed Care

States may enter into contracts with managed care entities to provide services to Medicaid beneficiaries and can require many beneficiaries to enroll in managed care plans. Managed care entities can deliver care through managed care organizations (MCOs), primary care case managers (PCCMs) or Prepaid Health Plans.[1] This issue of the Health Advocate will focus on arrangements using MCOs.

An MCO that participates in such an agreement assembles a "network" of providers to provide services to beneficiaries. While the Medicaid Act requires that enrollees have

[1] 42 U.S.C. §§ 1396u-2(a)(1)(B), 1396b(m)(1)(A) (regarding managed care organizations, 1396d(a)(25), 1396d(t) (regarding primary care case managers). For more on how these arrangements can work, *see* National Health Law Program ("NHeLP"), *The Advocate's Guide to the Medicaid Program* (May 2011, revised Sept. 2011), *available at* www.healthlaw.org; NHeLP, *Health Advocate: Medicaid Managed Care* (Sept. 2012), *available at* www.healthlaw.org/images/stories/2012_09_Vol_5_Health_Advocate.pdf.

"freedom of choice" to select a Medicaid provider, with limited exceptions, individuals enrolled in a Medicaid MCO must obtain covered services through a network provider or the MCO will not pay for the service.

Most MCO beneficiaries are enrolled in capitated plans under which the plan receives a set payment from the state per Medicaid enrollee. Under this arrangement, the plan will incur a loss if it spends more on services than it receives through capitated payments and makes a profit if it provides services costing less than the capitated payments — or by not providing services.

States relying on MCOs to deliver Medicaid services are bound by federal statutory requirements regarding choice of provider, and they must provide enrollment notices and informational materials to all enrollees and potential enrollees in a manner and form that they can easily understand. States must also ensure that the individual is informed in a written and prominent manner of any Medicaid benefits that are not available through the MCO. Other federal Medicaid requirements including limits on cost-sharing and the provision of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for beneficiaries under age 21 also apply to MCOs. Despite federal requirements, many women and adolescents enrolled in managed care may not be adequately informed of their rights, have access to covered reproductive health services or be able to obtain services from out-of-network providers.

For more on the legal requirements for Medicaid MCOs, see materials found in the Key Resources section.

Women's Health Services and Medicaid Managed Care

A woman's reproductive health is central to her overall health. Comprehensive care for women in Medicaid must include, at a minimum, physician visits; hospital care; family planning services and supplies; maternity care, including services furnished by a nurse-midwife and counseling and pharmacotherapy for cessation of tobacco use by pregnant women; mental health services and federally authorized abortion services. MCOs must comply with these requirements and must be carefully monitored to ensure that all enrollees are able to obtain the services they need as required by federal law.

Family Planning Services and Supplies

Congress expanded the mandatory Medicaid benefits package in 1972 to include family planning services and supplies furnished to eligible individuals of child-bearing age (including minors who can be considered to be sexually active). States have discretion in defining what constitutes a family planning service or supply, so long as the service is sufficient in amount, duration and scope to reasonably achieve its purpose. States vary widely as to which family planning benefits are covered, but generally include services such as counseling and patient education; laboratory exams and tests (e.g., STI testing); some or all FDA-approved methods, procedures, devices, and pharmaceutical supplies to prevent pregnancy; and limited infertility services, including sterilization reversals. States are required to ensure that Medicaid beneficiaries, including MCO enrollees, are free from any coercion or mental pressure when choosing their family planning method.

Recognizing the intimate nature of family planning services and the prolonged period of time that women require such services, the Medicaid Act provides that women enrolled in Medicaid maintain freedom of choice to select their family planning providers regardless of whether they obtain health care through a fee-for-service arrangement, a primary care case manager, or an MCO, so long as the family planning provider is willing to accept Medicaid payment for their services. This is critical in the managed care context where an MCO's in-network providers may not offer comprehensive women's health services.

Confidentiality and Managed Care

Federal and state laws, including Medicaid and Title X of the Public Health Service Act, explicitly guarantee confidential access to services. Medicaid requires that family planning services be provided confidentially to those who seek them, including sexually active minors. Confidentiality is a key factor in whether adolescents will access the full range of reproductive services covered by Medicaid. Studies have shown that adolescents who forgo health care due to confidentiality concerns are more likely to report health risk behaviors, psychological distress or unsatisfactory communication with parents. These studies suggest that adolescents at high risk of adverse health outcomes are less likely to use health care services when confidentiality is limited.

Confidentiality protections found in the Medicaid Act apply in both Medicaid managed care and fee-for-service delivery systems. Adolescent care providers should implement procedures to protect confidentiality, such as asking the adolescent where test results should be sent and not including details regarding the types of services provided to adolescents on billing or insurance statements (e.g., birth control pills).

Pregnancy

Low-income pregnant women, on average, experience higher rates of maternal mortality, preterm and low birth weight births and are more likely to experience high risk pregnancies due to co-occurring conditions like diabetes, hypertension and obesity than their wealthier counterparts. Low-income women and women of color are also more likely to experience unintended pregnancy and closely spaced births.

Pregnant women in Medicaid are entitled to physician and inpatient hospital services, including prenatal, delivery and post-natal care. Women entitled to Medicaid because of their pregnancy status must be provided all pregnancy-related services and other services related to conditions that may complicate the pregnancy. These conditions should be recognized to include dental care and treatment for diabetes, hypertension and urinary tract infections. These services must be provided without co-payments or deductibles.

It is difficult to ensure that all requirements for pregnancy coverage are being met in managed care systems. States are required to monitor compliance, but if the MCO does not collect consumer satisfaction information, or if its policies governing pregnant women's access to care are not transparent, it can be difficult for the state or consumers to identify violations and take corrective action. In addition, some managed care plans may not have the experience and expertise in their provider networks necessary to treat high-risk pregnant women. A 2007 study on Medicaid managed care in California found that the introduction of risk-based, capitated managed care was associated with increases in preterm deliveries, low birth weight babies and infant death.

Abortion

Rates of unintended pregnancy are higher among poor women and minorities. Compared to higher-income women, poor women and women of color are less likely to have access to abortion services. Many rely on government-sponsored health services, including Medicaid. Since 1977, Medicaid only allows coverage of abortion services when necessary to save the life of the mother or to end a pregnancy caused by rape or incest. Some states do provide abortion coverage with state-only funds in their medical assistance programs.

While federal funding for abortion services is extremely limited, prenatal care prior to an abortion, treatment of complications resulting from a medically unsupervised abortion and treatment of ectopic pregnancies are covered Medicaid services. Post-abortion tests and procedures performed to remedy complications resulting from a non-federally funded abortion are also covered, including extended hospital stays.

Health Care Refusals and Managed Care

Health care refusals can cause significant barriers to services in managed care. Individual providers may refuse to make referrals to needed services based on the provider's religious or ideological beliefs. The MCO network may not include hospitals and clinics that provide a full range of reproductive health services. State Medicaid managed care contracts with religiously-affiliated managed care organizations may exclude services to which the MCO has a religious objection. While the individual enrollee is still entitled to those services, it may be difficult for her to obtain them. Although the MCOs must inform patients or members about services they do not provide, this information may be hidden or difficult to find. Although MCOs do not have to inform enrollees about how to access excluded services, it is important to note that the state must provide this information to enrollees. Medicaid beneficiaries have the right to disenroll from a managed care plan "for cause" at any time if the plan or provider cannot meet the beneficiary's health needs because of moral or religious objections.

MCOs may not prohibit or restrict in-plan health care professionals from advising patients about their health status or need for medical treatment, regardless of whether benefits for that treatment are covered under the contract. However, the MCO is not required to cover or pay for counseling or referral services if the organization objects to the provision of such service on moral or religious grounds. The MCO must make information about such moral or religious policies available to prospective enrollees before or during enrollment.

Nondiscrimination

Over half of Medicaid beneficiaries are members of racial and ethnic minorities, and more than 60% of all beneficiaries are enrolled in managed care. MCOs must have in place mechanisms to identify and address health disparities as part of their health outcomes and quality assurance systems. Under the Affordable Care Act, certain data to identify health disparities must be collected in any federally conducted or supported health care or public health program.

Discrimination on certain bases by Medicaid MCOs is prohibited, and the contract between the state and MCO must reflect this. In particular, contracts must provide that the MCO will accept eligible individuals without restriction up to the limits set under the contract and may not discriminate against eligible individuals on the basis of health status or need for health care services. The contract must also state that the MCO may not discriminate against eligible individuals on the basis of race, color or national origin and may not use any policy or practice that has the effect of such discrimination.

Conclusion

State Medicaid programs increasingly rely on managed care. Implementation of the Medicaid Expansion, which has the potential to expand coverage to more than half of the currently 19 million uninsured women in the U.S., is likely to continue this trend. Understanding the intersections of women's health issues and managed care requirements is critical to ensuring that women's health and well-being are protected. NHeLP has numerous publications on managed care topics as well as women's health care issues. Please visit www.healthlaw.org for more information.

About Us

The National Health Law Program protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state level.

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