Medicaid Managed Care and Women's Health

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Date: August 9, 2013

Over the past 30 years, managed care has become the dominant service delivery model used for Medicaid programs across the country. The majority of low-income women and children enrolled in Medicaid now obtain services through managed care plans.[1] A key feature of many managed care arrangements is the requirement that enrollees obtain services from a specified network of providers. This can present challenges for meeting the unique needs of women. This paper provides an overview of special considerations for women's health coverage in Medicaid managed care.

Background

Providing access to services meeting the unique needs of diverse populations should be a key function of Medicaid managed care. Racial and ethnic minorities are disproportionately more likely than whites to rely on Medicaid for their health care, and these groups are also more likely to experience barriers to care, greater incidence of chronic disease, and higher mortality rates. Women's experience of these disparities is often exacerbated, as women of color disproportionately experience a variety of chronic health issues (hypertension, cardiovascular disease, diabetes) and in terms of HIV/AIDS, the case rate is 45.5 and 11.2 out of 100,000 for black and Latina women respectively, compared to 2 out of 100,000 for white women.[2]

Introduction to Medicaid Managed Care

States may enter into contracts with managed care entities to provide services to Medicaid beneficiaries.[3] The managed care entities authorized by Medicaid are managed care organizations (MCOs), primary care case managers (PCCMs), or Prepaid Health Plans.[4] This remainder of this paper focuses on arrangements using MCOs.

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[1] RACHEL B. GOLD & CORY L. RICHARDS, MEDICAID SUPPORT FOR FAMILY PLANNING IN THE MANAGED CARE ERA, THE ALAN GUTTMACHER INSTITUTE 14 (2001).
[2] CENTERS FOR DISEASE CONTROL AND PREVENTION, HIV/AIDS SURVEILLANCE REPORT (2007).
[3] *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (Aug. 5, 1997) (amending 42 U.S.C. § 1396b(m) and adding 42 U.S.C. §§ 1396d(t), 1396u-2). *See also* 42 C.F.R. §§ 438.1-438.812; HCFA, *Dear State Medicaid Director* (Dec. 17, 1997) (discussing specification of managed care benefits).
[4] 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 work, *see* National Health Law Program ("NHeLP"), *The Advocate's Guide to the Medicaid Program* (May 2011, revised Sept. 2011), *available at* http://www.healthlaw.org; NHeLP, *Health Advocate: Medicaid Managed Care* (Sept. 2012), *available at* http://healthlaw.org/images/stories/2012_09_Vol_5_Health_Advocate.pdf.

States can require many beneficiaries to enroll in managed care through an amendment to their state Medicaid plan.[5] If it does this, the state must comply with statutory requirements regarding beneficiary choice of provider, enrollment and disenrollment, and provision of information to beneficiaries.[6] States must obtain special permission (via a federal waiver) to require mandatory enrollment into managed care of the following populations: (1) children under age 19 with special needs;[7] (2) individuals who are dually eligible for Medicaid and Medicare, including Qualified Medicare Beneficiaries;[8] and (3) certain Native Americans.[9]

MCOs participating in Medicaid assemble "networks" of providers to provide services to the MCO's patient members. Generally, beneficiaries must obtain covered services through a network provider, or the MCO or Medicaid will not pay for the service. Beneficiaries are usually required to choose a primary care provider ("PCP") or a PCP is assigned for them. The PCP is the main provider for all of the beneficiary's health care. For most non-emergency services, the beneficiary must first go to the PCP, who can refer to a specialist if necessary.[10]

Most of the Medicaid beneficiaries enrolled in managed care are in capitated managed care plans, which receive a set payment per Medicaid enrollee in exchange for providing services.[11] Over 26 million of those enrolled in capitated managed care are in MCOs which have "comprehensive risk contracts." This means the MCO will incur a loss if it spends more on services than it receives through capitated payments.[12] The MCO can make a profit if it provides services costing less than the capitated payments -

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[5] 42 U.S.C. § 1396u-2.
[6] *See id.* § 1396u-2(a)(3)(A), 42 C.F.R. §§ 438.52(a), (b) (regarding beneficiary choice); §§ 1396u-2(a)(4)(A), (B), 42 C.F.R. §§ 438.56, 438.10(f)(1) (regarding enrollment and disenrollment); §1396u-2(a)(5)(A), 42 C.F.R. §§ 438.10(b), (c) and (d) (regarding provision of information).
[7] 42 U.S.C. § 1396u-2(a)(2)(A).
[8] *Id.* § 1396u-2(a)(2)(B); CMS, *Dear State Medicaid Director* (Aug. 2, 2001) (discussing enrollment of dual eligible beneficiaries into Medicaid managed care). Qualified Medicare Beneficiaries (QMBs) are individuals with income levels that qualify for Medicaid payment of some or all of the cost of Medicare cost-sharing, including Medicare Part A and B premiums, as well as deductibles, coinsurances, and copayments.
[9] *Id.* § 1396u-2(a)(2)(C). Permission can be obtained through a waiver pursuant to 42 U.S.C. § 1396n(b) or by applying for a demonstration waiver through § 1115 of the Social Security Act. 42 U.S.C. § 1315(a).
[10] NHeLP, *An Advocate's Guide to Reproductive Health in the Medicaid Program* (Feb. 2010) (available from NHeLP's Los Angeles office).
[11] CMS, Medicaid Managed Care Enrollment, July 1, 2010, https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/Downloads/2010July1.pdf.
[12] CMS, "Number of Managed Care Entity Enrollees by State" (July 1, 2010), https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/Downloads/2010MCE-Enrollees.pdf. *See also* 42 C.F.R. § 438.2 (defining MCO and comprehensive risk contract.)

or by not providing services. Thus, there is a clear incentive to limit or deny coverage of services for enrollees.

As discussed below, Medicaid covers a broad range of services that can meet the health needs of low-income women, and Medicaid also has special protections in place to ensure that women and adolescents receive certain services. These federal Medicaid standards are critical for protecting and promoting the health of low-income women. Therefore, when utilized, MCOs must be carefully monitored to ensure that all enrollees are able to obtain the services they need in a manner consistent with federal law.

Services

Medicaid services are particularly important for low-income women. In 2009, more than 22.4 million low-income women received basic and long-term health care coverage through Medicaid.[13] Nearly three-quarters of adult women on Medicaid are of reproductive age (18 to 44), and receive coverage for services including family planning, STD testing and treatment, pap smears, pregnancy-related care, and in limited cases, abortion services.

Generally, women tend to be poorer than men and are more likely to be employed in low wage or part-time jobs that do not offer health coverage, and at all ages, women make up the majority of beneficiaries receiving Medicaid coverage. Low-income women and women of color face a disproportionate burden of illness.[14] A woman's reproductive health is central to her overall health. The average American woman spends approximately 30 years of her life avoiding pregnancy.[15] Regardless of her ability or desire to have children, many conditions that affect a woman's overall health will also affect a pregnancy and the health of her children. Comprehensive care is necessary to allow women full participation in society. Medicaid can provide this comprehensive care, as it must cover, 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 subject to federal funding restrictions, permissible abortion services.[16]

State contracts with MCOs must specify the benefits for which the MCO is responsible.[17] At a minimum, each contract must include coverage of emergency services, as discussed above, inpatient hospital stays of 48 hours for normal deliveries

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[13] Kaiser Comm'n on Medicaid & the Uninsured & Urban Inst. analysis of 2009 MSIS.
[14] *See* The Henry J. Kaiser Family Foundation, *Medicaid's Role for Women: An Update on Women's Health Policy* (2007), *available at* www.kff.org/womenshealth/upload/7213_03.pdf.
[15] Wendy Chavkin & Sara Rosenbaum, *Women's Health and Health Care Reform: The Key Role of Comprehensive Reproductive Health Care* (Columbia Univ. Mailman Sch. of Public Health 2008), *available at* www.mailmanschool.org/facultypubs/womenshealthcarereform.pdf.
[16] 42 U.S.C. § 1396d(a).
[17] *Id.* § 1396u-2(b)(1); 42 C.F.R. § 438.10(e)(2)(ii)(A); HCFA, *Dear State Medicaid Director* (Dec. 30, 1997) (discussing beneficiary protections).

and 96 hours for cesareans. MCOs must not impose more restrictive lifetime or dollar limits on mental health benefits than on medical and surgical benefits.[18] The Medicaid Act requires an annual (as appropriate) external independent review of quality outcomes and timeliness of, and access to, the items and services covered under the managed care contract.[19]

Family planning services and supplies

Family planning services have long received special status in the Medicaid Program. Congress expanded the mandatory benefits package in 1972 to include "family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the state plan and who desire such services and supplies."[20] At the same time Congress established a special federal reimbursement rate for these services at 90%, with the state paying the remaining 10%.[21] The administrative costs related to offering, arranging, and furnishing family planning services and supplies are also covered by an enhanced match of 90%.[22] Many states also extend coverage through State Plan Amendments (SPAs) and § 1115 "demonstration projects" (also known as "waivers") to provide these services to individuals who do not otherwise qualify for Medicaid.[23]

The Medicaid Act also recognizes the intimate nature of family planning services, and the prolonged period of time that women require such services. Women enrolled in Medicaid have the right to choose their family planning providers regardless of whether they obtain health care through a fee-for-service arrangement or an MCO, so long as the provider is willing to accept Medicaid payment for their services.[24] CMS may, however, use its waiver authority to allow states to waive this freedom of choice requirement.[25]

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[18] *Id.* §§ 1396u-2(b)(2), (b)(8), 300gg-25, 26 (Newborns' and Mothers' Health Protection Act of 1996 and The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, respectively); 42 C.F.R. §§ 438.10(f)(6)(viii), 438.114; CMS, *Dear State Medicaid Director* (Apr. 18, 2000); HCFA *Dear State Medicaid Director* (Aug. 5, 1998; May 6, 1998; Feb. 20, 1998).

[19] 42 U.S.C. § 1396u-2(c)(2)(A) (external review); 42 C.F.R. §§ 438.204(d) (external review), 438.354 (qualifications of external quality review organization); HCFA, *Dear State Medicaid Director* (Jan. 20, 1998).

[20] *Id.* § 1396d(a)(4)(c).

[21] *Id.* § 1396b(a)(5); 42 C.F.R. § 433.10(c)(1). Federal reimbursement rates are generally calculated individually for each state for their expenditures on covered services, and typical rates vary from 50 percent to 83 percent. *Id.* § 1396d(b).

[22] *Id.* § 433.15(b)(2); CMS, STATE MEDICAID MANUAL § 11110.

[23] 42 U.S.C. § 1315(a); CMS, *Dear State Medicaid Director* (July 2, 2010) (discussing family planning and family planning related services in context of new eligibility option created under ACA § 2303).

[24] *Id.* §§ 1396a(a)(23), 1396n(b).

[25] *Id.* §§ 1315(a), 1396n(b). *See* Rachel Benson Gold & Cory L. Richards, *Medicaid Support for Family Planning in the Managed Care Era*, The Alan Guttmacher Inst. (2001), *available at* www.guttmacher.org/pubs/medicaid.pdf.

Federal law requires that states provide managed care enrollment notices and informational materials to all enrollees and potential enrollees, in a manner and form that they can easily understand. States must ensure that the individual is informed in a written and prominent manner of any Medicaid benefits that are not available through the entity.[26] The practical reality for women enrolled in an MCO is that despite federal requirements regarding the provision of plan information and the right to disenroll, many women may not be adequately informed of these rights, or out-of-network providers may not be readily available. MCOs may opt out of coverage for services if the organization objects to such service on moral or religious grounds.[27] Where this occurs, Medicaid beneficiaries retain 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.[28] 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.[29]

Pregnancy services

Low-income pregnant women tend to experience higher rates of maternal mortality, preterm and low birthweight births, and are more likely to experience high risk pregnancies due to co-occuring conditions like diabetes, hypertension, and obesity than their wealthier counterparts.[30] Low-income women and women of color are also more likely to experience unintended pregnancy and closely spaced births.[31]

Pregnant women in Medicaid are entitled to physician and inpatient hospital services, including prenatal, delivery, and post-natal care.[32] Women and adolescents 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, such as dental care, and treatment for diabetes, hypertension, or urinary tract infections.[33]

Medicaid also requires that pregnancy-related services be provided with no co-payments or deductibles. This includes not only prenatal care, labor and delivery, and post-partum care, but also services for conditions that might complicate pregnancy or

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[26] 42 U.S.C. § 1396u-2(a)(5)(D); 42 C.F.R. §§ 438.10(e)(2)(ii)(E), (f)(6)(xii). *See* Enrollment and Education section, below, for more on this.
[27] *Id.* § 1396u-2(b)(3)(B); 42 C.F.R. § 438.102(a)(2).
[28] 42 C.F.R. § 435.52(b)(2)(ii)(C).
[29] *Id.* § 438.102(b)(2).
[30] Kay Johnson, *Addressing Women's Health Needs and Improving Birth Outcomes: Results from a Peer-to-Peer State Medicaid Learning Project*, The Commonwealth Fund (Aug. 2012) *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2012/Aug/1620_Johnson_addressing_womens_htl_needs_improving_birth_ib.pdf.
[31] *Id.*
[32] 42 U.S.C. §§ 1396d(a)(5)(A), 1396d(a)(14), 1396a(a)(10)(ii)(II), 1396a(a)(10)(C)(iii).
[33] *Id.* § 1396a(a)(10)(i)(VII).

delivery. States can impose nominal cost-sharing for some prescription drugs, and women with income above 150% of the federal poverty level ("FPL") may be charged monthly Medicaid premiums.[34]

All of these special rules for pregnant women can promote early access to comprehensive and affordable pregnancy care. In reality, however, it is difficult to ensure that these protections are preserved in MCOs. States are required to monitor compliance to ensure that pregnant women have access to all of the services to which they are entitled and that they are not being charged for co-payments or deductibles in violation of federal law.[35] If the MCO does not collect consumer satisfaction information, or if it has poor transparency related to policies governing pregnant women's access to care, it can be difficult for the state or consumers to identify violations and take corrective action. Some MCOs also may not have the experience and expertise in their provider networks necessary to treat high-risk pregnant women, and a lag time between enrollment into a plan and initiating prenatal visits can cause significant delays in access to important health services early in pregnancy. In addition, MCOs must cover at least 48 hours of inpatient hospital stays for normal deliveries and 96 hours for cesareans.[36] Monitoring compliance with this requirement is critical because neonatal screenings and the identification of conditions such as jaundice require at least 24 to 48 hours in the hospital.[37]

Abortion Services

Rates of unintended pregnancy are higher among poor women and minorities.[38] In 2006, Medicaid was the primary payor for approximately two-thirds of the 1.6 million births resulting from unintended pregnancies. Compared to higher-income women, poor women are less likely to have access to abortion services to end an unintended pregnancy.[39] Poor women and women of color face the greatest barriers to obtaining abortions. Many rely on government-sponsored health services, including Medicaid. Yet, since fiscal year 1977, Congress has placed tight restrictions on Medicaid funding of abortions. 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.[40] Some states, however, provide state medical assistance funds for abortion services.[41]

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[34] *Id.* §§ 1396o(a)-(c); CMS, STATE MEDICAID MANUAL § 3591.5 (stating that premiums may be waived in hardship cases).
[35] *Id.* §§ 1396u(2)(c), 1396u-2(c)(1), (c)(2)(A); 42 C.F.R. §§ 438.202, 438.204, 438.242.
[36] *Id.* § 1396u-2(b)(8); 42 U.S.C. § 300gg-25 (Newborns' and Mothers' Health Protection Act of 1996).
[37] *See* Johnson, *supra* note 30.
[38] Lawrence B. Finer & Mia R. Zolna, *Unintended pregnancy in the United States: Incidence and Disparities, 2006*, 84 CONTRACEPTION 478 (2011).
[39] *Id.*
[40] Commonly known as the Hyde Amendment, this restriction has been attached to appropriation bills on an annual basis since 1976. *See* Consolidated Appropriations Act, Pub. L. No. 111-117, §§ 507, 508 (2010); Exec. Order No. 13,535, 75 Fed. Reg. 15,599 (Mar. 24, 2010); CMS, STATE MEDICAID MANUAL § 4430.
[41] The Alan Guttmacher Inst., *State Policies in Brief: State Funding of Abortion Under Medicaid* (July 2013), *available at* http://www.guttmacher.org/statecenter/spibs/spib_SFAM.pdf.

While federal funding for abortion services is extremely limited, it is important to note that prenatal care prior to an abortion, treatment of complications resulting from a medically unsupervised abortion, and treatment of ectopic pregnancies are covered Medicaid services.[42] Post abortion tests and procedures performed to remedy complications resulting from a non-federally funded abortion are also covered, including extended hospital stays.[43]

Refusal clauses are state and federal statutes or regulations that shield individuals and institutions from liability for failing to provide health services, counseling and/or referrals that patients would normally expect as part of their care. As discussed below, providers who rely on refusal clauses can seriously impede access to permissible abortion and/or abortion-related services. These refusals often directly contradict medical practice guidelines and standards of care, and as discussed below, the state and MCO are obligated to make information available so that women understand the limitations of their current plan.[44]

Access

State Medicaid programs must meet minimum standards regarding administration, eligibility, scope of services, and procedural protections. Participating states must guarantee access to certain services and protections to certain populations.[45] Procedural due process protections attach to eligibility and benefits for Medicaid, and state budgetary considerations regarding program funding, without more, generally will not excuse noncompliance with federal law.[46] At the same time, states have flexibility in designing and administering their programs, and there is variation in terms of benefits covered, covered populations, delivery systems, and methods of payment for services.

A Medicaid MCO must make covered services accessible to enrollees to the same extent such services are accessible to recipients not enrolled in the plan.[47] States may impose cost-sharing on beneficiaries enrolled in MCOs to the same extent that cost-sharing can be imposed on Medicaid beneficiaries not enrolled in the plan.[48] MCOs must also assure the state that they have the adequate capacity to serve the expected

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[42] CMS, STATE MEDICAID MANUAL § 4432.B.2.
[43] *Id.*
[44] *See* Susan Berke Fogel & Tracy A. Weitz, *Health Care Refusals: Undermining Quality Care for Women* (Feb. 2010).
[45] 42 U.S.C. § 1396u-7(a)(1)(E).
[46] *See Goldberg v. Kelly*, 397 U.S. 254 (1970). 42 C.F.R. §§ 431.200-431-231.
[47] 42 U.S.C. § 1396b(m)(1)(A)(i); 42 C.F.R. §§ 438.206(a), 438.207(a), (b) (MCOs must provide assurance of adequate capacity to serve enrollees in accordance with state's standards for access to care; *id*. § 438.207(d) (state must certify that MCO is in compliance with state's requirements for availability of services); *id.* § 438.208 (regarding coordination and continuity of care; *id.* § 438.210 (regarding coverage of services).
[48] 42 C.F.R. § 438.108; HCFA, *Dear State Medicaid Director* (Dec. 30, 1997).

enrollees, including an appropriate range of services; access to primary and preventive care; and a sufficient number, mix, and geographic distribution of providers.[49]

Federal regulations do not specifically define how MCOs are to ensure network adequacy; rather MCOs and states are left with significant discretion in defining network adequacy through state law or the managed care contracting process.[50] MCOs must demonstrate, to the state's satisfaction, however, that it provides an "appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of enrollees for the service area."[51] To ensure an appropriate range of women's health providers, enrollees should have meaningful access to all services they need, including contraception and abortion services, as well as maternity and newborn care. Network adequacy standards should do more than merely count the numbers and types of providers, but should ensure that there are sufficient types of providers or provider networks, including specialists, who actually provide all covered services. For example, ensuring the actual provision of services is especially important for women who may need covered reproductive health services, if some or all of the providers in the area do not provide those services.

Federal regulations also require that MCOs ensure adequate networks in consideration of the geographic location of providers and enrollees.[52] Medicaid requires that states ensure necessary transportation for beneficiaries to and from providers, and MCO enrollees must be properly notified of this benefit to avoid unnecessary burdens or delays in seeking care due to transportation constraints.[53] MCO-enrolled beneficiaries also have the right to a second opinion from a qualified health professional, and if none are available within the plans' network, the MCO must arrange for one outside the network at no cost to the enrollee.[54]

In many managed care systems, a beneficiary cannot refer herself to a specialist. Under federal Medicaid rules, however, MCOs must permit women to make appointments directly with OB/GYNs and other women's health specialists without a referral from her PCP. In addition, women enrolled in managed care are not limited to the family planning providers in the MCO's network.[55] Family planning services received out-of-network cannot cost more to the beneficiary than if she had obtained the services in-network.[56] A beneficiary is also not limited to the MCO network's emergency rooms in a medical emergency.[57] Subject to a reasonableness standard, the MCO must pay for emergency care even if obtained out-of-network. This means that the MCO must pay for the service

[49] *Id.* § 1396u-2(b)(5); 42 C.F.R. §§ 438.206(b)(1), 438.207(a), (b).
[50] 42 C.F.R. §§ 438.206-207.
[51] *Id.* § 438.207(b)(1).
[52] *Id.* § 438.206(b)(1)(v).
[53] 42 U.S.C. § 1396a(a)(4); 42 C.F.R. § 431.53. *See* STATE MEDICAID MANUAL § 2113.
[54] 42 C.F.R. § 438.206(b)(3).
[55] 42 U.S.C. § 1396a(a)(23)(B); 42 C.F.R. § 431.51(a)(3); CMS, STATE MEDICAID MANUAL §§ 2088.5, 2112.
[56] *Id.* § 1396u-2(b)(6)(C).
[57] *Id.* § 1396u-2(b)(2)(A)(i); 42 C.F.R. § 438.114(c).

if a "prudent layperson" would have thought she was having a medical emergency, even if it is later found that the condition did not require emergency treatment.[58]

Medical management techniques

The ACA requires most health plans to provide coverage for certain preventive health services without cost-sharing, including contraceptive services and supplies. This requirement applies to individuals in Medicaid receiving coverage through benchmark or benchmark-equivalent plans. These plans may be operated through managed care entities. Recently issued federal guidance announced flexibility for health plans covering preventive services, including family planning services and supplies, to utilize "reasonable medical management techniques" to determine the frequency, method, treatment or setting for any required services to the extent not already specified.[59] The term, while not specifically defined, is broadly understood to encompass insurer practices aiming to control costs and promote efficient delivery of care. **Figure 1** describes some of the various medical management techniques and how they may impede access to contraceptive coverage in Medicaid to the extent that Medicaid MCOs rely on them.

Figure 1: Medical management techniques and access to contraceptive services[60]

Prior authorization requires providers to obtain approval from the insurer that a recommended drug or device is necessary for the patient before it can be dispensed. Allows the plan to make an individualized determination about who can receive certain covered benefits.

Step therapy requires enrollees to try less expensive treatments before accessing more expensive options, even if those options are more effective, recommended by a provider, and preferred by the individual. This is commonly used to limit coverage of intrauterine devices (IUDs), requiring women to instead try less expensive contraceptive methods (oral birth control pills, for example) and experience failure or complications before granting access to an IUD.

Frequency limitations on how often beneficiaries can receive covered benefits can be used. For example, osteoporosis screenings are required by the preventive services guidelines "routinely" for women aged 65 and older, however, some group health plans have argued that reasonable medical management should allow limits on those screenings to once every five years even if a physician recommends more frequent screenings due to a family history of osteoporosis.

Formularies limit the number and types of drugs covered by a plan's prescription drug benefit. Medical management techniques could allow plans to continue charging cost-sharing for branded drugs if generic equivalents are available.

[58] *Id.* § 1396u-2(b)(2)(C); 42 C.F.R. § 438.114(a).
[59] 45 C.F.R. § 147.130(a)(4).
[60] For more on medical management and contraceptive coverage, *see* Erin Armstrong, *Medical Management and Access to Contraception*, NHeLP (May 2013), *available at* http://healthlaw.org/images/stories/Medical_Management_and_Access_to_Contraception.pdf.

Excluded services

MCOs generally cover most of the day-to-day health care needs of Medicaid members. Some MCOs may not contract to pay for more complicated, specialty, or unusually expensive care. Such Medicaid services are said to be "carved out" of the MCO's contract, meaning they are not required to cover them. Dental and mental health care are examples of services often carved out. Some states have entered into Medicaid managed care contracts that allow religiously controlled plans to "carve out" the Medicaid-covered reproductive health services to which they object.[61] In such cases, Medicaid beneficiaries must obtain the necessary care out of the MCO network. Restrictions such as this necessitate extra steps to obtain needed care, and can result in barriers to access. The state must inform beneficiaries which services are "carved out" and how and where they may obtain that care out of the MCO network.[62] 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.[63] 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.[64] The MCO must make information about such moral or religious policies available to prospective enrollees before or during enrollment.[65]

Confidentiality

Federal and state laws explicitly guarantee confidential access to services, including Medicaid and Title X of the Public Health Service Act. Medicaid requires confidentiality in the provision of family planning services to those who seek them, including sexually active minors.[66] Confidentiality is of particular importance for adolescent health. Confidentiality is a key factor in whether adolescents will access the full range of reproductive services covered. Studies have also shown that adolescents who forgo health care due to confidentiality concerns are more likely to also report health risk behaviors, psychological distress and/or unsatisfactory communication with parents. These studies suggest that if confidentiality restrictions are increased, health care use is likely to decrease among adolescents at high risk of adverse health outcomes.[67]

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[61] *See* Patricia Miller & Celina Chelala, *Catholics for a Free Choice: Catholic HMOs and Reproductive Health Care*, www.catholicsforchoice.org/topics/healthcare/documents/2000catholichmos.pdf.
[62] 42 C.F.R. § 438.10(f)(6)(viii).
[63] 42 U.S.C. § 1396u-2(b)(3)(A); 42 C.F.R. § 438.102(a); HCFA, *Dear State Medicaid Director* (Feb. 20, 1998) (discussing "anti-gag rule").
[64] *Id.* § 1396u-2(b)(3)(B).
[65] *Id.*
[66] *Id.* § 1396a(a)(7)(A).
[67] *See* Jocelyn A. Lehrer, et al., *Forgone Health Care among U.S. Adolescents: Associations between Risk Characteristics and Confidentiality Concern*, 40 J. OF ADOLESCENT. HEALTH 218 (Mar. 2007).

Confidentiality protections found in the Medicaid Act must apply in both Medicaid managed care as well as fee-for-service plans.[68] Providers of reproductive health care to adolescents should be aware of ways to protect confidentiality, for example, asking where test results should be sent and not including services provided to adolescents on billing or insurance statements.

Most states allow minors to consent to a range of reproductive health services beyond family planning (including prenatal care and delivery) as well as to treatment for substance abuse disorders and mental health care; in addition, all states allow minors to consent to testing and treatment services for STDs.[69] Medicaid coverage of abortion, discussed above, is limited to cases involving rape, incest, or life endangerment of the woman, although some states fund abortions with state-only funds.. If a minor is seeking a permissible abortion under Medicaid, confidentiality concerns can add a major barrier to access. Minors' access to confidential abortion services is often quite restricted, with many states requiring parental notification or consent prior to obtaining an abortion.[70] Each of these states is required to have in place a procedure for minors to obtain approval from a court or to allow another adult relative to be notified or consent to the procedure, and most parental notification laws allow doctors to forego parental involvement in cases of medical emergency or abuse, assault, incest, or neglect.[71]

Enrollment and Education

Enrolling in the right health plan is critical to ensuring that needed services are covered and affordable. The enrollment process can create unique challenges for women and adolescents in the managed care context. States are required to establish processes for enrollment, termination of enrollment, and change of enrollment.[72] All enrollment notices and informational materials must be provided in a manner and form that is easily understood by enrollees and potential enrollees.[73] Before enrolling an individual in managed care, the state must ensure that the individual is informed in a written and prominent manner of any Medicaid benefits that are not available through the MCO, and how access to those benefits may be obtained elsewhere.[74] Upon request, the MCOs must provide enrollees and potential enrollees with specific information concerning the identity, location, qualifications, and availability of participating providers; enrollee rights and responsibilities; grievance and appeal procedures; and covered items and services.[75] States must also ensure that high risk groups (e.g. pregnant women,

[68] 42 U.S.C. § 1396a(a)(7); 42 C.F.R. §§ 431.300-431.306; 431.940-432.965.
[69] Cynthia Dailard & Chinue Turner Richardson, *Teenagers' Access to Confidential Reproductive Health Services*, 8 Guttmacher Report on Public Policy 4 (2005).
[70] *Id.*
[71] *Id. See also Bellotti v. Baird*, 443 U.S. 622 (1979) (state law requiring pregnant minor seeking an abortion to obtain parental consent is an unconstitutional burden on her right).
[72] *Id.* §§ 1396u-2(a)(4)(A), (B); 42 C.F.R. §§ 438.56, 438.10(f)(1) (regarding disenrollment).
[73] *Id.* § 1396u-2(a)(5)(A); 42 C.F.R. §§ 438.10(b), (c), and (d); HCFA, *Dear State Medicaid Director* (Feb. 20, 1998) (provision of information and effective dates).
[74] *Id.* § 1396u-2(a)(5)(D); 42 C.F.R. §§ 438.10(e)(2)(ii)(E), (f)(6)(xii).
[75] *Id.* § 1396u-2(a)(5)(B); 42 C.F.R. § 438.10(f).

adolescents, foster children) receive targeted outreach, however MCOs have been found to fail to carry out such outreach.[76]

The process must link Medicaid beneficiaries to health plans that are available and accessible.[77] The managed care health plans offered must provide access to services comparable to those in traditional Medicaid.[78] Additionally, state Medicaid agencies must provide, annually and upon request, a chart comparing managed care plan benefits, cost-sharing (if any), as well as quality and performance indicators.[79] Generally, states must allow beneficiaries to choose between at least two managed care entities.[80] In rural areas, however, states can require enrollment in a single managed care entity so long as the individual has a choice of at least two physicians or case managers.[81]

Poorly chosen health plans and hasty enrollment can lead to confusion, dissatisfaction, unmet needs, heavy turnover, and grievances. Adolescents' ability to select their own MCO is critical to meeting their health care needs. While managed care contracts almost always allow "every member" to select his or her own MCO, it is not always clear if this extends to minors, or allowing members of the same family to select separate MCOs.

Consumer education, including through online resources and face-to-face interviews, is a way to ensure ongoing support for individuals on their options, rights and responsibilities. Counselors providing enrollment support should reflect the ethnic, linguistic, and cultural demographics of the population served. Once informed of the various options, there should be adequate time for an individual to choose a plan, and MCOs must work to ensure that school-based and teen clinic programs can be included so that adolescents can self-select among these providers.

Special Populations

Adolescents

Adolescents have numerous and complex health needs. All adolescents need regular check-ups, and most need contraceptive services and STD screenings. Many adolescents need treatment and monitoring for chronic health conditions, including asthma, or behavioral health services. Adolescents are also disproportionately more

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[76] CMS, STATE MEDICAID MANUAL § 5121. A 1999 study conducted by NHeLP staff found that only Massachusetts and New Hampshire required MCOs to provide educational information on health promotion and wellness relevant to the specific health status needs and characteristics of adolescents. *See* Massachusetts Managed Care Contract, Appendix A (App. A, p. 6); New Hampshire Managed Care Contract § 2.23 (p. 14), Exhibit A.3 (Ex. A.3, p. 6) (available from NHeLP's Los Angeles office).

[77] *Id.* § 1396n(b); 42 C.F.R. § 438.206(a)).

[78] *Id.* § 1396b(m)(1)(A)(i); 42 C.F.R. § 438.206.

[79] *Id.* § 1396u-2(a)(5)(C); 42 C.F.R. § 438.10(i).

[80] *Id.* § 1396u-2(a)(3)(A); 42 C.F.R. § 438.52(a); HCFA, *Dear State Medicaid Director* (Jan. 14, 1998) (discussing choice of managed care entity).

[81] *Id.* at § 1396u-2(a)(3)(B); 42 C.F.R. § 438.52(b).

likely to experience poor nutrition, mental and emotional illness, suicidal thoughts, chronic illness, pregnancy, STDs, and substance use, all of which have been described as "preventable health conditions with predominantly behavioral and environmental etiologies."[82] Poor youth tend to have higher rates of pregnancy, STDs, HIV, and substance use than their wealthier counterparts, and health problems are particularly acute for minority youth. Across all adolescent health problem measures, black and Latino adolescents are disproportionately affected, and black children are approximately three times more likely than white children to be hospitalized for asthma.[83]

The Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service is a broad benefit package offering comprehensive coverage to children and adolescents.[84] EPSDT is a mandatory Medicaid service that must be provided for Medicaid-eligible children and youth up to age 21. Medicaid-eligible children and youth are entitled to EPSDT's comprehensive benefits include regular medical, dental, vision and hearing check-ups, immunizations, laboratory tests, health education, and a schedule of regular, age-appropriate health screens, and treatment for conditions detected.[85]

Federal law requires that all adolescents eligible for Medicaid be informed of the availability of EPSDT services.[86] The state Medicaid agency must aggressively seek out eligible adolescents and inform them, using a combination of oral and written methods.[87] The state Medicaid agency must offer, "necessary assistance" with transportation and scheduling appointments for services to families with eligible children.[88]

Most state agencies include the requirement to cover EPSDT services in compliance with federal law in contracts with MCOs. Contract language describing the EPSDT requirement, however, is not always consistent across states. While noting the broad authority to cover services required by federal law, contracts can often lack specificity

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[82] David S. Rosen et al., *Clinical Preventive Services for Adolescents: Position Paper of the Society for Adolescent Medicine*, 21 J. ADOLESCENT HEALTH 203 (1997).
[83] Tracy A. Liu et al., *Race, Ethnicity, and Access to Ambulatory Care among U.S. Adolescents*, 83 AM. J. PUB. HEALTH 960 (1993); Laurie Emmer, *The Impact of Poverty on Adolescent Health*, 3 ADOLESCENT HEALTH 2 (2003). For more on adolescent health needs and Medicaid, *see* NHeLP, *Addressing Adolescent Health: The Role of Medicaid, CHIP, and the ACA* (Nov. 5, 2012), *available at* http://healthlaw.org/images/stories/Adolescent_Health_Issue_Brief_11.5.12.pdf.
[84] 42 U.S.C. §§ 1396a(a)(10), (43), 1396d(a)(4)(B), 1396d(r); 42 C.F.R. §§ 441.50-441.62; CMS, STATE MEDICAID MANUAL §§ 5010-5360. For a comprehensive guide to the EPSDT program, see NHeLP, *Toward a Healthy Future: Medicaid Early and Periodic Screening, Diagnostic, and Treatment Services for Poor Children and Youth* (April 2003) (available from NHeLP's Los Angeles office).
[85] *See Toward a Healthy Future*, NHeLP; Jane Perkins, *Medicaid Early and Periodic Screening, Diagnosis and Treatment Fact Sheet* (NHeLP 2008).
[86] 42 U.S.C. § 1396a(a)(43).
[87] 42 C.F.R. § 441.56(a)(1); CMS, STATE MEDICAID MANUAL § 5010.
[88] 42 U.S.C. § 1396a(a)(43); 42 C.F.R. § 441.62.

regarding the details of EPSDT coverage. By providing a list of minimally required covered services, while specifying that the list is not closed-ended, as part of the contract with MCOs, states can ensure adequate coverage of this category. **Figure 2** provides an example of how a state might specify EPSDT minimum standards for health education in their managed care contracts.

The way MCO contracts define medical necessity is also important. Despite the broad federal EPSDT necessity standard for treatment, some definitions may allow for a significant degree of discretion in determining the scope of services considered medically necessary. For example, some contracts may list a restricted set of services tied to health events, rather than including broader language that allows coverage of all services necessary for health maintenance.

Figure 2: Massachusetts HMO Model Contract[89]

> "Health Education/Anticipatory Guidance. Age-specific and appropriate counseling must be delivered by providers to parents, guardians, and adolescents about common and expected developmental advancements and common physical problems. Effective discussion includes assessment and teaching based on a family-centered, culturally competent approach. Discussion topics should include, but not be limited to, parents' concerns; developmental expectations and good parenting practices; behavioral risks, such as substance use and violence; sexuality; AIDS and other communicable diseases; depression; injury prevention; and nutrition. Educational activities and resources (such as printed brochures, audiovisual materials, class instruction) can enhance comprehensive child and adolescent health supervision but should not replace provider/recipient interaction. The American Medical Association's Guidelines for Adolescent Preventive Services and/or the American Academy of Pediatrics' Guidelines for Health Supervision II provides lists of topics to be discussed at adolescent periodic visits."

Women with Disabilities

Increasing numbers of people with disabilities are being required to enroll in Medicaid managed care. Where the state has entered into a risk-based contract with an MCO, it can be costly to serve this population, thus increasing the risk undertaken by the MCO. In 2009, 43% of Medicaid expenditures were made for individuals under age 65 with disabilities, despite the fact that these enrollees comprise only 15% of the total Medicaid enrollment.[90] Because MCO's contracts require the plan to incur a loss if it spends more

[89] Massachusetts Managed Care Contract, Appendix G § 450.142 (App. G, pp. 1-34) (available from NHeLP's North Carolina office).

[90] Kaiser Comm'n on Medicaid & the Uninsured, *Distribution of Payments by Medicaid Enrollment Group FY 2009*, http://www.statehealthfacts.org/comparetable.jsp?ind=200&cat=4&sub=52&yr=90&typ=2 (last visited April 26, 2013); Kaiser Comm'n on Medicaid & the Uninsured, *Distribution of Medicaid Enrollees by Enrollment Group FY 2009*, http://www.statehealthfacts.org/comparetable.jsp?ind=200&cat=4&sub=52&yr=90&typ=2 (last visited April 26, 2013).

on services than is received through its contract, there is a strong incentive for the MCO to deny or limit access to services to keep costs down.

Women with disabilities are more likely to experience depression, diabetes, osteoporosis, obesity, and high blood pressure than other women.[91] Women with disabilities may also experience increased physical, cognitive, emotional, or psychosocial complications as a result of their primary disabling conditions, which can be due to several factors, including: overuse, underuse, or misuse of an already weakened neuromuscular system; complications resulting from the original injury, disease, or treatment; or poor coping and lifestyle behaviors.[92] Women and adolescents with disabilities are also at greater risk, both in and out of the home, of violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation.[93]

Women with disabilities may face added barriers, especially in managed care systems. Women with disabilities need the same general health care as women without disabilities, but may also need specialty care to address their individual needs. They also face societal misperceptions about their sexuality. Research has shown that women with disabilities may not receive regular breast and cervical cancer screenings as recommended by professional guidelines.[94] Studies also show higher rates of death related to breast cancer among women with a disability, even if they are diagnosed at the same stage as a woman without a disability.[95] With the national rate of routine mammography for MCOs averaging below 50%, this disparity for women with disabilities is exacerbated.[96]

Low-income women with disabilities often face the same cost barriers to health care as other women, but may face additional barriers such as limited access to specialty care due to a limited managed care provider network; they may delay seeking care due to the high cost of specialty care, multiple office visits, prescriptions, or medical equipment to meet their needs; they may have difficulty obtaining private insurance, and where available, certain services or medical equipment may not be adequately covered by their MCO to meet their needs; women with disabilities may also experience difficulty physically accessing services due to poor compliance by providers with equipment or architectural accessibility requirements.[97]

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[91] Margaret A. Nosek, *Women, Disability, and Health Care Reform*, Center for Research on Women With Disabilities (June 2008).
[92] Margaret A. Nosek, *Women with Disabilities as a Health Disparities Population*, Center for Research on Women with Disabilities (Apr. 2009).
[93] Convention on the Rights of Persons with Disabilities, preamble (q), 2515 U.N.T.S. 4 (Dec. 13, 2006).
[94] Brian S. Armour et al., *State-Level Differences in Breast and Cervical Cancer Screening by Disability Status*, 19 WOMEN'S HEALTH ISSUES 406 (Nov. 2009).
[95] Ellen P. McCarthy et al., *Disparities in Breast Cancer Treatment and Survival for Women with Disabilities*, 145 ANNALS OF INTERNAL MEDICINE 637 (Nov. 2006).
[96] Sharada Weir et al., *Disparities in Routine Breast Cancer Screening for Medicaid Managed Care Members with a Work-Limiting Disability*, 1 MEDICARE & MEDICAID RESEARCH REVIEW E1 (2011).
[97] Nosek, *supra* note 86.

Women Living with HIV

Women living with HIV ("WLWH") make up approximately a quarter of those living with HIV in the US, and these women are disproportionately women of color and low-income women. Medicaid is a critical access point for uninsured low-income women into the necessary and comprehensive treatment regime for HIV care that would allow them to live healthier lives.

WLWH generally have the same health needs as all women. In addition, the health goals for individuals with HIV are to suppress the HIV viral load (preferably to undetectable levels), improve quality of life, restore or preserve immune function, and prevent HIV transmission to partners.[98] The usual recommended treatment course for people living with HIV is Highly Active Antiretroviral Therapy ("HAART").[99] Strict adherence to the HAART regimen is necessary for optimal health and to prevent drug resistance.[100] WLWH therefore require specific services and treatment in primary and gynecological care, as well as access to health providers with expertise in women's health and HIV.[101] Medicaid coverage for WLWH is critical, and with the ACA's expansion of Medicaid, enrollment in the program by WLWH is likely to increase significantly in the coming years.[102]

MCOs can pose additional challenges for low-income WLWH. These women have reported difficulty in affording cost-sharing requirements, even when low or nominal, for the covered services they need in their plan.[103] Other barriers include difficulty accessing HIV specialists in the MCO plan network and affording the prescription copays for non-covered medications where the MCO does not cover HIV drugs at all. Women also report challenges getting referrals to HIV specialists as well as the additional cost barrier for women enrolled in those plans who must seek care out-of-network.[104]

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[98] Am. C. Obstetrics & Gynecology, Practice Bulletin 117, *Gynecologic Care for Women with Human Immunodeficiency Virus* (Dec. 2010).

[99] N.Y.U. Center for AIDS Research, et al., *HIV Info Source: HIV Treatment Options* (Jan. 22, 2009), *available at* http://www.hivinfosource.org/hivis/hivbasics/treatment/index.html.

[100] NAT'L ACAD. OF SCIENCES, PUBLIC FINANCING AND DELIVERY OF HIV/AIDS CARE: SECURING THE LEGACY OF RYAN WHITE (2005).

[101] 30 for 30 Campaign, *Briefing Paper: Making HIV Care and Treatment Work for Women* (Mar. 2012), *available at* http://www.aidsalabama.org/documents/Making%20HIV%20Care%20and%20Treatment%20Work%20for%20Women.pdf.

[102] For more on WLWH, Medicaid, and the ACA, *see* Jina Dhillon & Deborah Reid, *Addressing the Needs of Low-Income Women Living with HIV: The Role of Medicaid and the ACA*, National Health Law Program (April 2013), *available at* http://healthlaw.org/images/stories/NHeLP_Q&A_Women_HIV_ACA.PDF.

[103] Kaiser Fam. Found., *The Healthcare Experience of Women with HIV/AIDS: Insights from Focus Groups* (Oct. 2003), *available at* http://www.kff.org/hivaids/uploads/The-Healthcare-Experiences-of-Women-with-HIV-AIDS-Insights-from-Focus-Groups-pdf.pdf.

[104] *Id. See also* Nat'l Acad. of Sciences, *Public Financing, supra* note 86.

WLWH can also face increased discrimination and stigma, particularly where state laws and policies fuel such an atmosphere. Unlawful provider refusals to provide health care and services disproportionately impact people living with HIV. One study in Los Angeles County found illegal refusals when individuals posing as people living with HIV attempted to access care.[105] Such illegal and discriminatory practices can pervade many different health care settings, including managed care.

Nondiscrimination

As many as half of Medicaid beneficiaries are members of racial and ethnic minorities, and more than 60% of all beneficiaries are enrolled in managed care.[106] 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 ("ACA"), certain data to identify health disparities must be collected in any federally conducted or supported health care or public health programs.[107] This includes the collection of race and ethnicity data regarding underserved rural and frontier populations. Previously, while states often collected race and ethnicity data, there was no standardized methodology. This has resulted in a patchwork of race and ethnicity data that cannot be compared across states. Under the ACA, however, states will be required to use the Office of Management and Budget ("OMB") standards to collect this data.[108] States must also develop new standards for collecting sex, primary language, and disability status data, and minimum standards require self-reported data to be collected from the beneficiary, or from a parent or legal guardian if the beneficiary is a minor or legally incapacitated.[109]

Discrimination by Medicaid MCOs is prohibited and the contract between the state and MCO must reflect this.[110] 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, on the basis of health status or need for health care services, discriminate against eligible individuals.[111] 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.[112]

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[105] Brad Sears, The Williams Institute, Los Angeles Daily Journal, *Brad Sears on Addressing HIV Discrimination in Health Care* (Dec. 2, 2011), *available at* http://williamsinstitute.law.ucla.edu/headlines/brad-sears-on-addressing-hiv-discrimination-in-health-care/.
[106] Centers for Medicare and Medicaid Services, *Fiscal Year 2003 National MSIS Tables*, *available at* http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/MSISTables2003.pdf.
[107] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 4302 (Mar. 23, 2010) ("ACA").
[108] *Id.*
[109] *Id.*
[110] 42 C.F.R. § 438.6(d).
[111] *Id.*
[112] *Id.*

MCO contracts must also prohibit discrimination on the basis of health status or in requirements for health services in the enrollment, disenrollment, and re-enrollment processes.[113] States must also ensure that the capitated rates paid to MCOs themselves are adequate to cover necessary services for enrollees.

Individuals enrolled in Medicaid managed care can also rely on the protections in Section 504 of the Rehabilitation Act ("Section 504"), which prohibits programs receiving federal funding from engaging in discrimination against people with disabilities.[114] Title II of the Americans with Disabilities Act ("ADA") prohibits discrimination and requires entities to make reasonable accommodations to ensure that individuals with disabilities can participate in public services and programs. It also requires that services be provided in the most integrated setting appropriate to an individual's needs.[115] Title II applies to State Medicaid agencies, but not directly to MCOs. However, all governmental activities of public entities are covered by Title II, even if they are carried out by contractors.[116]

In addition to these protections, Section 1557 of the ACA prohibits discrimination on the basis of race, color, national origin, sex, age, and disability in health programs or activities that receive federal funding. States have the ultimate responsibility for ensuring compliance with federal Medicaid requirements, as well as the ADA, Section 504, and Section 1557.

Conclusion

State Medicaid programs increasingly rely on MCOs. 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 US, is likely to continue this trend. Understanding the intersections of various women's health issues and managed care requirements is critical to ensuring that women's health and well-being is protected. NHeLP has numerous publications on managed care topics as well as women's health care issues. Please visit http://www.healthlaw.org for more information.

[113] *Id.* § 1396b(m)(1)(A); 42 C.F.R. § 438.700.
[114] 29 U.S.C. §§ 794, 794a. For more on Medicaid managed care and discrimination protections, *see* Sarah Somers, *Q&A: Medicaid Managed Care and Disability Discrimination Protections*, NHeLP (May 2012), *available at* http://healthlaw.org/images/stories/QA_May_2012_Disability_Discrimination.pdf.
[115] 42 U.S.C. § 12132; 28 C.F.R., pt. 35, App. A.
[116] 28 C.F.R., pt. 35, App. A.