Medicaid Managed Care Final Regulations and Reproductive Care

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Prepared By: Catherine McKee

This issue brief will review selected provisions in the final rule, *Medicaid and Children's Health Insurance Program (CHIP) Programs, Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability*, implementing requirements governing access to reproductive health services in Medicaid managed care.[1] While much of the final rule affects access to reproductive health services, this issue brief focuses on changes to the requirements that are specific to these services. We also include recommendations to help state advocates ensure robust implementation of these requirements in their states.

Network Adequacy and Access to Services

Capitated Medicaid managed care plans generally require enrollees to receive services from a specific network of providers.[2] If plans fail to contract with sufficient numbers and types of providers, enrollees might not have timely access to all covered services. Timely access to family planning, prenatal, and abortion services is especially critical. Given state law restrictions on abortion, including gestational limits and waiting periods, women must have the ability to see an abortion provider without further delays caused by the managed care plan.

[1] *Medicaid and Children's Health Insurance Program (CHIP) Programs, Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability*, 81 Fed. Reg. 27,498-27,901 (May 6, 2016), https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf.

[2] This issue brief refers to managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans collectively as "capitated plans." These terms are defined at 42 C.F.R. § 438.2.

The final regulations make a number of improvements to the requirements related to network adequacy and access to services.[3] The improvements designed to increase access to reproductive health providers and services are described below.[4]

Travel time and distance standards (§ 438.68)

In a major change, the final rule requires capitated plans to follow specific, state-established quantitative standards with respect to the amount of travel time and the distance between enrollees and providers. Under both the previous and revised versions the regulations, states must ensure that plans establish a network of appropriate providers that is sufficient to provide adequate access to all services covered under the contract.[5] The previous version of the rule required plans to consider the geographic location of providers and enrollees, including travel time and distance and the means of transportation commonly used by enrollees. However, it did not require states to set specific quantitative measures to evaluate whether the time and distance between enrollees and providers are in fact reasonable.

Under the final rule, states must create time and distance standards for eight provider types, including primary care providers and OB/GYNs. CMS may require states to establish standards for other provider types to promote the objectives of the Medicaid program.[6] While standards must apply in every geographic area of the state where a capitated plan operates, the standards may differ based on the geographic area.[7]

[3] For an in-depth discussion of the requirements governing network adequacy and access to services, *see* ABBI COURSOLLE, NAT'L HEALTH LAW PROGRAM, MEDICAID MANAGED CARE FINAL REGULATIONS: NETWORK ADEQUACY & ACCESS (2016), http://www.healthlaw.org/issues/medicaid/managed-care/Brief-3-MMC-Final-Reg#.V17WUPkrKM9.

[4] The changes go into effect for the rating period for contracts beginning on or after July 1, 2018. The rating period is "the twelve month period for which capitation rates are developed under a managed care contract, to address States that have multi-year managed care contracts." CMS, Medicaid and CHIP Final Rule (CMS 2390-F) Implementation Dates (Apr. 25, 2016), https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/implementation-dates.pdf (last visited June 14, 2016).

[5] 42 C.F.R. § 438.206(b)(1).

[6] *Id*. States must publish their time and distance standards on their website and also make them available in accessible formats to enrollees with disabilities upon request. *Id*. § 438.68(e).

[7] *Id*. § 438.68(b)(3). A state may allow a plan to obtain an exception to its time and distance standards under certain circumstances. *See id*. § 438.68(d).

NHeLP urged CMS not to focus solely on OB/GYNs, but instead to require states to develop time and distance standards for access to women's health care services more broadly defined, including family planning, prenatal, and abortion services. Enrollees receive these services from a variety of provider types in addition to OB/GYNs, such as family practitioners, nurse practitioners, physician assistants, and certified nurse midwives. NHeLP also encouraged CMS to set national minimum time and distance standards for all of the provider types identified in the final rule.[8] CMS declined to adopt these recommendations.

State Advocacy Tip

Advocates should work closely with their states to ensure that they develop meaningful time and distance standards for access to women's health care services, including family planning, prenatal, and abortion services.

Timely availability of services (§ 438.206)

Although the final rule does not require states to develop time and distance standards for family planning providers in particular, it does add a new requirement designed to ensure the timely availability of family planning services. Under the "freedom of choice" provision of the Medicaid Act, managed care enrollees have the right to obtain covered family planning services from the qualified Medicaid provider of their choice, whether that provider is in-network or out-of-network.[9] In addition, states must ensure that if a plan cannot provide covered services in-network, it provides adequate and timely access to the services out-of-network at no additional cost to the enrollee.[10]

While these protections are critical, enrollees must have access to family planning and other reproductive health services in-network. Enrollees might not always be able to locate an out-of-network provider in a timely manner. In addition, when enrollees receive family planning services in-network, they benefit from the care coordination that plans should be providing. Thus, the final regulations require states to ensure that every capitated plan demonstrates that "its network includes sufficient

[8] *See* Letter from Elizabeth G. Taylor, Executive Dir., Nat'l Health Law Program, to Victoria Wachino, Dir. Ctr. For Medicaid & CHIP Servs., Ctrs. For Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs. 84-86 (July 27, 2015), http://www.healthlaw.org/publications/comments-managed-care#.Vcfw-PnmNO8.
[9] 42 U.S.C. §§ 1396a(a)(23), 1396n(b); *see also* 42 C.F.R. § 431.51(b)(2).
[10] 42 C.F.R. § 438.206(b)(4)-(5) (2002).

family planning providers to ensure timely access to covered services."[11] Further improvements are needed to ensure that enrollees have timely access to all covered family planning and reproductive health services in-network.

Like the previous version of the regulations, the final regulations do not explicitly require plans to take into account whether providers refuse to provide certain services due to a moral or religious objection. An increasing number of hospitals, clinics, and individual providers refuse to offer certain family planning services, such as sterilization services or emergency contraception, as well as other reproductive health services, such as appropriate treatment for pregnancy complications, abortions, and transition-related services for transgender individuals.[12] As a result, some plans might compile a network that appears to include sufficient numbers and types of providers, when in fact, enrollees do not have timely access to all covered reproductive health services in-network.

Advocates should urge states to explicitly require capitated plans to evaluate the numbers and types of providers who refuse to provide certain reproductive health services due to a moral or religious objection. Plans that contract with providers who refuse to provide the full range of reproductive health services should take additional steps to guarantee that enrollees have timely access to all covered services in-network. In particular, plans should contract with at least one institutional provider and one professional provider offering the services that other in-network providers refuse to deliver. If there is no such provider in the geographic area, plans must contract with providers in a neighboring area and provide transportation.

[11] 42 C.F.R. § 438.206(b)(7). *See also* 81 Fed. Reg. 27,667 ("While the ability to choose a family planning provider from outside a managed care plan's network is an important beneficiary option, we do not believe it negates the managed care plan's responsibility to ensure timely access within its network.")

[12] Many Catholic health systems prohibit affiliated providers from offering these services. As of 2011, 10 of the 25 largest health systems in the country were Catholic. LOUIS UTTLEY AND SHEILA REYNERTSON, MERGERWATCH, AND LORRAINE KENNY AND LOUISE MELLING, AMERICAN CIVIL LIBERTIES UNION, MISCARRIAGE OF MEDICINE: THE GROWTH OF CATHOLIC HOSPITALS AND THE THREAT TO REPRODUCTIVE HEALTH CARE 1 (2013), https://www.aclu.org/sites/default/files/field_document/growth-of-catholic-hospitals-2013.pdf.

State Advocacy Tip

Advocates should encourage states to clarify that capitated plans must allow enrollees to see an out-of-network provider when the only provider or facility available in-network refuses to deliver a covered service due to a moral or religious objection. Likewise, plans must permit enrollees to see an out-of-network provider when the enrollee needs related services that would subject the enrollee to unnecessary risk if received separately (for example a tubal ligation at the time of delivery), and not all of the services are available in-network.

Direct access to providers (§ 438.206)

Generally, capitated plans require enrollees to have a referral from their primary care provider before seeing a specialty provider. However, as noted above, plans may not restrict enrollees' access to the family planning provider of their choice. In addition, both the previous and revised versions of the regulations require capitated plans to allow female enrollees to directly access an in-network women's health specialist for "covered care necessary to provide women's routine and preventive health care services" if her primary care provider is not a women's health specialist.[13]

While the final rule does not change this requirement, the preamble further explains its meaning. CMS notes that the term "female enrollees" includes minors.[14] This is important, as it prevents plans from taking the position that only adult women have the right to directly access a women's health specialist.

State Advocacy Tip

Advocates should urge states to clarify that all enrollees who need the services specified, including transgender men, may directly access a "women's health specialist."

[13] 42 C.F.R. § 438.206(b)(4) (2002).
[14] 81 Fed. Reg. 27,667.

In addition, CMS explains that "routine and preventive health care services" includes "initial and follow-up visits for services unique to women such as prenatal care, mammograms, pap smears, and for services to treat genitourinary conditions such as vaginal and urinary tract infections and sexually transmitted diseases."[15] Although helpful, this guidance is not sufficient to remove unnecessary barriers to care for enrollees. For example, plans might mistakenly believe that abortions do not qualify as "routine and preventive health care services" and not allow enrollees to directly access abortion care. This is an even greater problem for enrollees whose primary care provider refuses to refer for abortion services due to a moral or religious objection.

State Advocacy Tip

Advocates should encourage states to require capitated plans to permit enrollees to directly access a women's health specialist for all covered women's health services. The same requirement should apply to primary care case management (PCCM) entities that require enrollees to have a referral before seeing a specialty provider. At the very least, states should ensure that plans and PCCM entities have a process in place to ensure enrollees have timely access services when their primary care provider refuses to provide a referral for the services due to a moral or religious objection.

Information Requirements (§ 438.10)

The final rule makes substantial revisions to the requirements regarding the provision of information to enrollees and potential enrollees.[16] Among these revisions are two subtle but significant changes that will improve access to reproductive health services.[17]

First, the final regulations add a new requirement regarding services that a capitated plan or PCCM entity refuses to cover for moral or religious reasons. Under the old regulations, the state or its

[15] *Id*.

[16] For a thorough discussion of the changes related to access to information for individuals with limited English proficiency and individuals with a disability, *see* MARA YOUDELMAN, NAT'L HEALTH LAW PROGRAM, MEDICAID MANAGED CARE FINAL REGULATIONS AND HEALTH EQUITY (2016), http://www.healthlaw.org/publications/browse-all-publications/Brief-1-MMC-Final-Reg#.V17S7_krKM9.

[17] The changes become effective for the rating period for contracts beginning on or after July 1, 2017. 81 Fed. Reg. 27,499.

contracted representative must inform potential enrollees, and the state, its contracted representative, or the managed care entity must inform enrollees about benefits that are available under the state plan, but are not covered by the plan.[18] For a counseling or referral service not covered by the plan due to a moral or religious objection, the state must tell potential enrollees and enrollees how and where to obtain the service.[19]

Under the final regulations, the capitated plan or PCCM entity is responsible for providing enrollees with a handbook listing the benefits that are provided directly by the state.[20] When a plan or PCCM entity refuses to cover a counseling or referral service due to a moral or religious objection, the plan or PCCM entity itself must inform enrollees how and where to obtain information from the state about how to access the service.[21] Because enrollees are accustomed to seeking and receiving information about covered benefits from their plan or PCCM entity, this requirement will help ensure that enrollees have the information needed to access services that their plan refuses to cover. Advocates should encourage states to extend this requirement to potential enrollees as well.

State Advocacy Tip

Potential enrollees and enrollees also need to know when in-network providers refuse to offer particular reproductive health services due to a moral or religious objection. States should require plans to indicate in their provider directories if a provider refuses to offer certain services for moral or religious reasons.

Second, the final rule alters the information that must be provided to enrollees about their right to see the family planning provider of their choice. Under both the previous and revised versions of the regulations, enrollees must be informed of "[t]he extent to which, and how . . . [they] may obtain benefits, including family planning services and supplies from out-of-network providers."[22] In addition, the final regulations require managed care entities to clarify that enrollees cannot be required to obtain a referral before seeing a family planning provider.[23] This change will help enrollees understand the scope of their right under the freedom of choice provision.

[18] 42 C.F.R. § 438.10(e), (f) (2002).
[19] *Id*. § 438.10(e)(1)(ii)(E), (f)(6)(xii). *See also* 42 U.S.C. § 1396u-2(b)(3)(B).
[20] 42 C.F.R. § 438.10(g)(2)(i).
[21] *Id*. § 438.10(g)(2)(ii)(A)-(B). The final regulations made a parallel change in § 438.102(b). Notably, capitated plans must comply with this section beginning July 5, 2016. 81 Fed. Reg. 27,498-99.
[22] 42 C.F.R. § 438.10(f)(6)(vii) (2002).
[23] 42 C.F.R. § 438.10(g)(2)(vii).

Utilization Controls (§ 438.210)

The final regulations make an important change with respect to utilization controls for family planning services and supplies. Utilization controls include prior authorization for services, quantity limits on services, and step therapy (try and fail). Plans that use step therapy generally require enrollees to first try a less expensive or invasive service, supply, or drug unless contraindicated. If the first option fails to achieve the desired result or causes side effects, plans then approve a more expensive or invasive option.

When utilization controls align with medical standards of care, they can improve efficiency and effectively control health care costs. However, when applied to family planning services and supplies, most utilization controls are simply inappropriate. Medical standards of care require that individuals have access to the contraceptive method that they prefer. The American College of Obstetricians and Gynecologists instructs providers that "in the absence of contraindications, patient choice should be the principal factor in prescribing one method of contraception over another."[24] In recognition of this principle, Medicaid regulations require states to ensure that Medicaid enrollees are "free from coercion and mental pressure and free to choose the method of family planning to be used."[25]

The final managed care regulations explicitly incorporate this requirement. Consistent with the previous version of the regulations, the final rule allows capitated plans to adopt their own utilization controls. Plans may "place appropriate limits on a service . . . [f]or the purpose of utilization control, provided that [t]he services furnished can reasonably achieve their purpose . . ."[26] However, the final rule adds that family planning services must be "provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with § 441.20 of this chapter."[27]

The preamble explains that plans may not use utilization controls that "effectively deprive" enrollees of "free choice of equally appropriate [family planning] treatments."[28] Thus, plans may not use step therapy or adopt policies that restrict a change in method.[29] Similarly, "[s]tates and managed care plans

[24] AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, GUIDELINES FOR WOMEN'S HEALTH CARE: A RESOURCE MANUAL 183 (3rd ed. 2007).
[25] 42 C.F.R. § 441.20.
[26] 42 C.F.R. § 438.210(a)(4)(ii).
[27] *Id*. The changes to § 438.210 go into effect for the rating period for contracts beginning on or after July 1, 2017. 81 Fed. Reg. 27,499. However, this particular change does nothing more than refer to existing law. As a result, plans should adhere to this requirement immediately. *See* CMS, Dear State Health Official Letter (June 14, 2016) (providing guidance, effective immediately, on the interaction between § 441.20 and utilization controls).
[28] 81 Fed. Reg. 27,634.
[29] *Id.*; CMS, Dear State Health Official Letter 2 (June 13, 2016).

should avoid practices that delay the provision of a preferred method or that impose medically inappropriate quantity limits, such as allowing only one long acting reversible contraceptive (LARC) insertion every five years, even when an earlier LARC was expelled or removed."[30] However, CMS left open the possibility that plans may require prior authorization to determine that a particular family planning "method is medically necessary and appropriate for the individual, using criteria that may include considerations such as severity of side effects, clinical effectiveness, differences in permanence and reversibility of contraceptives, and ability to adhere to the appropriate use of the item or service."[31] This is problematic. By definition, family planning services are medically necessary for enrollees of child-bearing age who desire them. Advocates should work closely with their states to ensure that plans do not adopt inappropriate utilization controls for family planning services.

State Advocacy Tip

As states are revising their contracts, advocates should encourage them to explicitly require plans to provide family planning services and supplies without prior authorization, restriction, or delay.

Conclusion

The final regulations include a number of provisions designed to improve enrollees' access to reproductive health services, and present a number of opportunities for state advocates to strengthen or clarify the final regulations. NHeLP recommends that state advocates monitor development of policies, contracts, practices, and implementation to ensure that:

- States adopt robust time and distance standards for access to women's health care services, including family planning, prenatal, and abortion services, which may be provided by OB/GYNs, family practitioners, nurse practitioners, physician assistants, certified nurse midwives, and other provider types.
- Capitated plans, when establishing and maintaining their networks, account for the numbers and types of providers who refuse to provide certain reproductive health services due to a moral or religious objection.
- Capitated plans that contract with providers who refuse to provide particular reproductive health services guarantee that enrollees have timely access to these services. These plans should contract with at least one institutional provider and one professional provider offering the services that other in-network providers refuse to provide. If there is no such provider in the

[30] CMS, Dear State Health Official Letter 2 (June 13, 2016).
[31] *Id*.

geographic area, plans must contract with providers in neighboring areas and provide transportation.

- States explicitly require capitated plans to allow enrollees to see an out-of-network provider when the only provider or facility available in-network refuses to deliver a covered service due to a moral or religious objection. Likewise, plans must be required to permit enrollees to see an out-of-network provider when the enrollee needs related services that would subject the enrollee to unnecessary risk if received separately (for example a tubal ligation at the time of delivery), and not all of the services are available in-network.
- Capitated plans and PCCM entities permit all enrollees who need women's health services, no matter their gender identity, to directly access a women's health specialist for all covered women's health services. At the very least, plans should have a process in place to allow enrollees to access services when their primary care provider refuses to provide a referral for the services due to a moral or religious objection.
- Plans' provider directories indicate if a provider refuses to offer certain services due to a moral or religious objection.
- Capitated plans and PCCM entities that refuse to provide a counseling or referral service for moral or religious reasons inform both potential enrollees and enrollees about how and where to obtain information from the state about how to access the service.
- States prohibit plans from adopting inappropriate utilization controls. Plans should provide family planning services and supplies without prior authorization, restriction, or delay.

For further information about implementing these tips, please contact the National Health Law Program.