Medicaid Managed Care and Due Process Rights: What Do HMOs Have to Tell You When They Deny Reproductive Health Services?

July 1999

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A. Medicaid is Important to Women of Childbearing Age

Medicaid is a major source of health coverage for women. In 1996, for example, Medicaid covered 7.8 million women (1 out of 10 non-elderly women),[1] and paid for four out of 10 births in the United States.[2] The program also is a major payor of reproductive health services for low-income women, men and adolescents. Half of all public dollars for family planning services and supplies in the United States are provided by the Medicaid program.[3]

Women make up the majority of individuals enrolled in the Medicaid program (58 percent),[4] and over one-third are in their childbearing years.[5] Managed care has become the major health care delivery system for Medicaid beneficiaries.[6] Medicaid managed care is most often mandated for women of childbearing age and their children.[7]

B. Reproductive Health Services Are Vital to Good Health

The availability of reproductive health services is essential to the health and well-being of low-income women.[8] Yet, many women enrolled in Medicaid managed care organizations (MCOs) risk denial of these services. For example, religious Medicaid MCOs that are Catholic must adhere to the Ethical and Religious Directives. Depending on how these Directives are interpreted locally, an MCO may not cover one or more of the following services:[9]

- Contraceptive Services and Supplies
- Sterilizations
- Fertility Treatments
- Abortion
- Emergency Contraception for Rape Victims
- Condoms to Combat the Spread of HIV/AIDS and other STDs

Federal law allows a religious MCO to avoid provision of, reimbursement for, and coverage of services if the MCO has a moral or religious objection to the services.[10] Under this law, MCOs also may escape referral or counseling services for reproductive health care.[11] Non-religious MCOs also often contract with religious hospitals and clinics that require similar restrictions on reproductive services as a condition of the contract.

Other problems in accessing reproductive health services in Medicaid MCOs have been reported to include:[12]

- Illegal Imposition of Fees on Contraceptive Services
- Lack of Information on the Scope of Covered Services
- Lack of Choice of Contraceptive Provider

The point of denial may occur at the health plan level where, for example, a prior authorization request for a service is denied. It also may occur at the provider level. A primary care provider may have his or her own religious or moral objections or may know or erroneously assume that the health plan does not cover a particular service. These issues undermine women□s access to reproductive health services.

C. Freedom of Choice Protections Must Be Enforced But Are Limited

Beneficiaries enrolled in Medicaid MCOs maintain their □freedom-of-choice□ to access family planning services from any Medicaid-participating family planning provider.[13] Family planning services are available from non-MCO network providers.

While important, this right only goes so far:

Freedom-of-choice applies only to family planning. Not all reproductive health services fall under this protection. Some related services must be obtained within the health plan. For example, labor and delivery is an in-plan service. If an MCO or a contracting hospital does not provide family planning services, a woman needing a tubal ligation, which is considered family planning, will have to schedule a second surgery out-of-plan after she gives birth.

Women cannot exercise their rights if they are uninformed. Women must have clear, up-front information and disclosure about their ability to access services from out-of-plan providers. However, women, and most often adolescents, do not receive such verbal and written notice.

D. Due Process Rights Afford Protection to Reproductive Health Access

Women receive important protection through their notice and fair hearing rights. The United States Constitution requires that MCOs provide written notice individually to women denied a service, including reproductive health services, because:

Medicaid benefits (including family planning and other reproductive health services)[14] are a matter of statutory entitlement for persons qualified to receive them.[15]

Medicaid beneficiaries have a constitutional property interest in their benefits. When a state actor (e.g., the state Medicaid agency) acts to deny, delay, terminate, suspend, or reduce a Medicaid-

covered service, the state actor must provide advance written notice and an opportunity to challenge the action before an impartial hearing officer.[16]

Courts have recognized MCOs as state actors that are subject to this requirement.[17]

Because of these Constitutional protections, a woman who is denied reproductive health services must be provided with a written notice and an opportunity to challenge the denial at a fair hearing. For example, a religious MCO that denies a request for family planning services or a tubal ligation at the time of labor and delivery must provide the patient with a timely written notice. The notice must contain an explanation of:

- the intended action (e.g., denial),
- the reasons for the action, and
- the facts and the laws that support it.[18]

In addition, the right to notice and fair hearing should be triggered when the health plan denies a prior authorization request or refuses to pay for a service. Arguably, this right also should be triggered when a provider fails to furnish a needed service when the denial is not based on the provider□s determination of whether a service is medically necessary, but based on known or assumed health plan policies (which may be an incorrect assumption) or on the provider□s individual religious or moral beliefs.

Women should receive written notices about the services that they are being denied so that they can challenge illegal rules, access needed services out-of-plan, or switch to health plans or providers that do provide the full scope of reproductive health services.

A woman also can challenge the imposition of a fee on family planning services,[19] or can challenge a health plan□s restriction of choice of family planning providers.[20]

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1 Diane Rowland, et al., The Key to the Door: Medicaid□s Role in Improving Health Care for Women and Children, 20 Ann. Rev. Pub. Health 403, 404 (1999), citing J. Horton, Jacobs Inst. Women□s Health, State Profiles on Women□s Health (1998).

2 Id., citing National Gov.□s Ass□n, MCH Update: State Medicaid Coverage of Pregnant Women and Children (1997).

3 Rachel Benson Gold, Key Policies Emerging to Govern delivery of Family Planning in Medicaid Managed Care, 2 The Guttmacher Report on Public Policy 3 (Feb. 1999).

4 Health Care Financing Administration, U.S. Dep□t Health & Human Services, Medicaid Recipients and Vendor Payments By Sex (Table 7) (last modified Feb. 6, 1998) (reporting on the years 1994-1996).

5 Health Care Financing Administration, U.S. Dep□t Health & Human Services, Medicaid Recipients as a Percentage of Population by Age (Table 9) (last modified Feb. 6, 1998)

(reporting on the years 1994-1996) (out of a total of 36.1 million Medicaid beneficiaries in 1996, 11.4 million (over 31 percent) are between the ages of 15 and 44.

6 Health Care Financing Administration, U.S. Dep□t Health & Human Services, Medicaid Managed Care Enrollment □ June 30, 1998 (last modified April 8, 1999) (Nationwide, 53.6 percent of Medicaid beneficiaries are enrolled in managed care plans and over 50 percent of the Medicaid population in 31 states is enrolled in Medicaid managed care).

7 See, e.g., Calfornia Department of Health Servs., 1998 Managed Care Annual Statistical Report (March 1998), Table 2.3 (showing that most individuals between the ages of 15 and 45 who are in the mandatory enrollment Medi-Cal aid categories are female.).

8 Alan Guttmacher Institute, Support for Family Planning Improves Women□s Lives, (visited Jul. 11, 1999) .

9 See National Conf. Of Catholic Bishops, Ethical and Religious Directives for Catholic Health Care Services (Rev. 1996).

10 42 U.S.C. § 1396u-2(b)(3)(B).

11 This language is a rule of construction within □anti-gag□ language which prohibits health plans from limiting the information that health care providers can share with their patients. 42 U.S.C. § 1396u-2(b)(3). Because MCOs cannot □gag□ providers, religious MCOs cannot prevent health providers from disclosing information about all the services that their patients might need, either by prohibiting the provider from discussing the information or by financially punishing a provider who otherwise includes that information in an office visit.

12 Benson Gold, supra note 3 at 3-4.

13 42 U.S.C. § 1396a(a)(23)(B).

14 For a discussion on the scope of services covered by Medicaid, see Fact Sheet: Medicaid Coverage of Reproductive Health Services, Health Advocate (National Health Law Program, Los Angeles, CA), Summer 1998, at 8.

15 Goldberg v. Kelly, 397 U.S. 254, 262 (1970).

16 Id.; Moffit v. Austin, 600 F. Supp. 295, 297 (W.D. Ky. 1984); 42 C.F.R. §§ 431.200 et seq.

17 See e.g., Perry v. Chen, 985 F. Supp. 1197, 1202 (D. Ariz. 1996) (holding that Medicaid MCOs are state actors). This analysis may change, depending on the outcome of Grijalva v. Shalala, 152 F. 3d 1115 (9th Cir. Ariz.), cert. granted, judgement vacated by Shalala v. Grijalva, 119 S. Ct. 1573 (while the 9th circuit held that Medicare MCOs are state actors, the Supreme Court, upon granting a petition for writ of certiorari, remanded the case to the 9th Circuit for further consideration in light of the Court□s decision in American Manufacturers Mutual

Insurance Company v. Shalala, 119 S.Ct. 977 (1999) which held that actions by the Pennsylvania State Workers Insurance Fund could not be attributed to the state).

18 42 C.F.R. § 431.210. Additional information that must be included is: the right to request a hearing; the circumstances in which a hearing will be granted (in cases in changes of law); and the circumstances the benefits will be continued if a hearing is requested. Id.

19 Under federal Medicaid, no cost-sharing can be imposed on family planning services. 42 U.S.C. §§ 1396o(a)(2)(D), 1396o(b)(2)(D).

20 See, supra note 13 and accompanying text.

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