New Rules Issued to Govern Delivery of Family Planning Under Medicaid Managed Care

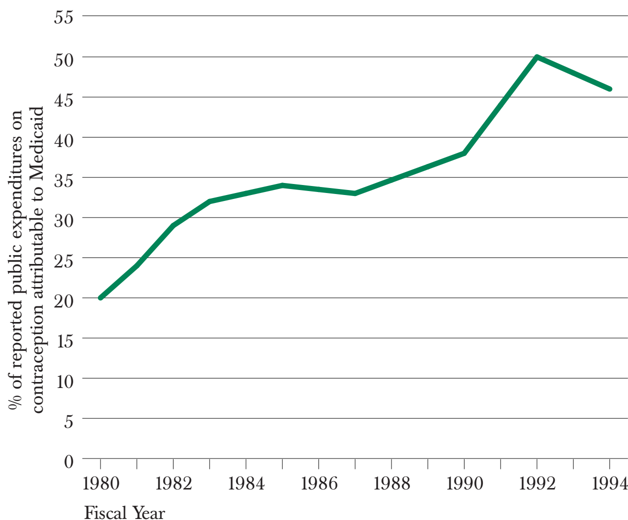
By Rachel Benson Gold

On its last full day in office, the Clinton administration formally promulgated the long-awaited regulation to implement the Medicaid managed care sections of the Balanced Budget Act of 1997. Within the 200-page notice are several critical provisions that clarify the rights Medicaid enrollees have in seeking the family planning services to which they are legally entitled and the obligations that states and managed care plans have in ensuring that these services are provided.

Almost as soon as the rule was promulgated, however, its implementation—along with a number of other last-minute actions—was delayed by a moratorium issued by the Bush administration on January 20. Meanwhile, the National Governors Association launched a campaign urging the regulation's repeal, claiming that it is too prescriptive and would be prohibitively expensive for states to implement. As a result, the future of the first uniform national standards for Medicaid managed care—and for the delivery of family planning services in the managed care era—are far from clear.

A Critical Program

The contribution of Medicaid to public funding of family planning has increased dramatically.



Source: Gold RB and Richards CL, *Medicaid Support for Family Planning in the Managed Care Era,* New York: The Alan Guttmacher Institute, 2001.

Medicaid and Family Planning

Medicaid, the joint federal-state program that funds health care services for low-income Americans, is vitally important to the provision of publicly funded family planning services and supplies in the United States. Family planning is one of the few services that federal law mandates all state Medicaid programs to cover, creating a legal entitlement to "family planning services and supplies" for Medicaid recipients, including sexually active teenagers. Medicaid's importance as a source of public funds for family planning has grown enormously; it now provides half of all public dollars spent on contraceptive services and supplies (see chart).

Along with health care in the United States generally, Medicaid has undergone an important transition over the last two decades. It has moved from a program that exclusively paid for care on a fee-for-service basis to one increasingly organized around managed care. By 1999, more than half of all Medicaid recipients obtained their care through managed care plans (see chart, page 6). Low-income women and their dependents, the Medicaid population most likely to be in need of family planning, are also the most likely to be enrolled in managed care.

This transition has been accomplished largely by individual states obtaining waivers from the Health Care Financing Administration (HCFA), the arm of the Department of Health and Human Services that administers Medicaid on the federal level, to make modifications that would otherwise not be allowed under the federal statute. Requiring recipients to enroll in managed care plans is a prime example of a state initiative requiring a waiver, because it violates a fundamental tenant of the statute, the guarantee that Medicaid enrollees are entitled to seek services from the provider of their choice. Each waiver application is reviewed and approved separately by HCFA, which usually sets special terms and conditions. The result is a patchwork of varying federal requirements for Medicaid managed care programs nationwide.

Balanced Budget Act Standards

This situation changed dramatically with the passage of the Balanced Budget Act. At the heart of that measure is a basic bargain: The federal government will abandon the requirement that states obtain waivers in order to mandate enrollment in managed care plans, in return for which, states must abide by a series of federal requirements governing most of their Medicaid managed care efforts. (States may, of course, continue to operate their waiver programs, which are not governed by the new regulation.)

While the Balanced Budget Act provided the basic principles, the details were left to the implementing regulation. HCFA proposed the regulation in late 1998 ("Key Policies Emerging to Govern Delivery of Family Planning in Medicaid Managed Care," *TGR*, February 1999, page 3), and, after spending two years reviewing more than 300 public comments, it published a final

rule on January 19, 2001, the day before President Clinton left office.

The standards embodied in the Balanced Budget Act and the implementing regulation, if allowed to take effect, would have dramatic—and generally quite positive—implications for the delivery and accessibility of family planning services and supplies in Medicaid managed care environments.

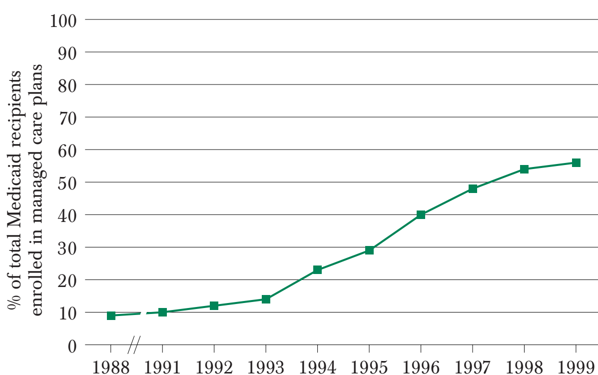
Ensuring Access to Care

Medicaid recipients—including those enrolled in managed care plans—have a legal right to all covered services. The regulation makes clear that if a specific service that is covered by Medicaid is not included in a contract negotiated between a managed care plan and the state, the state is responsible for ensuring access to that care.

For services that are included in their contracts with state Medicaid agencies, plans are obligated to ensure access. The regulation specifically requires plans to have a sufficient network of providers—in terms of the number, type and geographic distribution—to meet enrollees' needs in a timely manner.

Managed Care Growth

Medicaid managed care enrollment has climbed sharply in the past decade.



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Enrollees not having adequate access to covered services within a network may obtain that care outside the network. Further, the preamble to the regulation clarifies that if a network provider determines that an enrollee needs care related to a covered service and is unable to get that care within the network, the enrollee may obtain that care from a provider not affiliated with the plan. The specific example used to illustrate this situation is a tubal ligation following a cesarean delivery, an attempt to address the problems caused by the refusal of some religious providers or plans to cover postpartum sterilizations.

Allowing Plans to Opt Out

The Balanced Budget Act allows *any* plan, whether or not it is religiously controlled or even affiliated, to refuse to cover counseling and referral services to which the plan has a religious or moral objection. The rule attempts to implement that provision by establishing a set of principles that seeks to maintain enrollees' ability to access the care to which they are entitled when a plan chooses to opt out of providing even counseling or referral.

The rule makes explicit that enrollees have a right "to receive from their health care providers the full range of medical advice and counseling that is appropriate for their condition." While plans may refuse to *pay for* counseling and referral services to which object, they may not interfere with the communication between a patient and a provider.

The regulation also requires that a plan refusing to cover counseling and referral services inform its enrollees, as well as the state, of its decision. The plan must tell enrollees where and how to obtain *information* about services it will not cover, but it is the responsibility of the state to tell them where and how to obtain the actual care. For example, the state could require a plan to give women the number of a toll-free hotline that could then provide information about family planning services, but it could not require the plan to give enrollees the names of actual service providers.

Retaining Freedom of Choice

Since the 1980s, federal law has required most waivers mandating managed care enrollment to allow enrollees to obtain family planning services and supplies from the provider of their choice, even if that provider is not affiliated with their plan. Both the Balanced Budget Act and the regulation retain this "freedom of choice" provision. In addition, the regulation requires enrollees to be notified of this right.

The Balanced Budget Act and the regulation are somewhat less clear on the related question of direct access—that is, without having to first obtain permission from a primary care provider. The law says that enrollees must be given direct access to providers of "women's health care." The regulation specifies that the providers in question include certified nurse practitioners and nurse midwives as well as physicians. However, the regulation says only that direct access is available for services "unique to women such as prenatal care, mammograms, pap smears, and for services to treat genito-urinary conditions such as vaginal and urinary tract infections and sexually transmitted diseases." While there is no reason to believe that family planning services are meant to be excluded, the use of a limited set of examples may cause confusion at the state level, where the provision will be implemented.

Information Given to Enrollees

The provision of information to Medicaid managed care enrollees is one of the key elements of both the law and the regulation. The regulation provides a detailed list of the information that must be provided,

including the benefits covered by the plan and how to access covered services. It also requires enrollees to be informed of any cost-sharing that is required. Notably, while plans may impose cost-sharing for most services covered under Medicaid, long-standing provisions of the Medicaid statute specifically prohibit plans from requiring cost-sharing for family planning services and supplies.

Plans must also give enrollees information about services that are covered by Medicaid in the state but are not covered by the plan (that is, not included in the plan's contract with the state). The regulation specifically requires plans to tell potential and current enrollees how and where to access these services, any cost-sharing requirements that may be imposed and how transportation is provided.

Prognosis Guarded

The moratorium imposed by President Bush has the immediate effect of postponing implementation of the regulation, which had been set for April 19, for an additional 60 days. Because the rule was published in final form, however, the administration would have to officially retract it in order to make changes. Any changes would necessitate a new proposed rule and a new period for public comment. So far, the administration is saying only that it is studying the matter.

Meanwhile, several proposals to revamp Medicaid are also making their way to the table. A coalition of consumer advocates and the health insurance industry is proposing a two-pronged strategy of expanding Medicaid eligibility to provide coverage to more low-income Americans by requiring state Medicaid programs to cover all individuals with incomes up to 133% of the federal poverty level, with eligibility based solely on family income. (Currently each state sets its own eligibility ceilings, which average 46% of poverty nationwide.) The plan would also provide public subsidies for small businesses to purchase private insurance for their employees. And the governors, who are leading the charge against what they consider to be the costly and unnecessary mandates of the regulation, have made a sweeping proposal to overhaul the entire Medicaid program and greatly increase state flexibility. Clearly, the future of Medicaid will be a major topic on the public agenda in the coming months, with the new managed care regulation squarely in the middle of the fray.

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