Proposed New Rules for Medicaid Managed Care Could Impede Family Planning Access

By Rachel Benson Gold

Enacted in 1965, the Medicaid program has been transformed in recent years from a program organized around a fee-for-service model of financing and service delivery to a program that uses managed care as its main organizing principle. This transformation has been especially profound for low-income women and children covered under the program, most of whom are now enrolled in managed care plans. Until recently, the federal government did little in the way of national policy-making for the Medicaid managed care effort; instead a patchwork of sometimes widely differing state programs provided care to eligible enrollees.

This situation changed dramatically with the passage of the Balanced Budget Act of 1997, which established the first uniform national standards for Medicaid managed care. As is often the case, the legislation lays out a basic framework for a policy, with many of the details to be supplied by implementing regulations developed by the agency responsible for implementation, in this instance, the Department of Health and Human Services (DHHS). After spending more than two years considering roughly 300 public comments, DHHS released Medicaid managed care regulations on the last full day of the Clinton presidency ("New Rules Issued to Govern Delivery of Family Planning Under Medicaid Manage Care," *TGR*, April 2001, page 5). The next day, however, the Bush administration imposed a moratorium on many of the last-minute Clinton actions, including the Medicaid regulations, saying it needed time to review the policy changes.

In mid-August, the Bush administration formally proposed an entirely new set of managed care rules. This new proposal was designed primarily to address concerns raised by the National Governors Association, which has long advocated for increased flexibility in administering the state Medicaid programs. DHHS staff seem to have gone through the old rules line by line, making innumerable small deletions and wording changes, virtually all of which appear aimed at reducing the demands on managed care plans and states. While some of these changes may not be terribly significant, others could have serious implications. This article discusses the major provisions of the proposed regulations that are directly relevant to enrollees' access to family planning services and supplies.

Access to Covered Services

Under Medicaid, enrollees are legally entitled to services covered under their state programs, and states are legally obligated to provide access to that care. The Balanced Budget Act specifically requires that plans maintain a network of providers sufficient to meet the anticipated needs of their enrollees and that the network include the number and types of providers necessary to furnish the services included in the contract and to provide needed care in a timely manner.

The proposed regulations would require plans to assure the state that they have met these requirements when they enter into a contract and any time there is a significant change in the plan's capacity. If a plan cannot provide timely access to covered services to a particular enrollee within its network of providers, it must cover those services from an out-of-network provider. Enrollees would have the right to disenroll from a plan at any time if it fails to provide them with adequate access to covered services.

Because the underlying Medicaid statute has long required all state programs to cover family planning services and supplies, recipients—including managed care enrollees—have been legally *entitled* to obtain that care. In addition, the underlying statute since the mid-1980s has enabled almost all managed care enrollees to obtain family planning from the provider of their choice, even if that provider is not affiliated with the enrollee's managed care plan, and prohibits plans or states from charging fees for Medicaid-covered family planning services and supplies. The Balanced Budget Act did not disturb these key statutory provisions specific to family planning, and the proposed regulations explicitly restate them.

The proposed regulations would allow women to have direct access—that is, without having to obtain a referral from a primary care provider—to another provider within the network for "routine and preventive health care services." While the Clinton rule included a list of examples of the services for which direct access would be available to women, one that was not explicit with regard to family planning, there is no list of examples at all in the proposed regulations. As a result, family planning advocates will be working to restore a list of services for which direct access is available, and to ensure that family planning is included on that list, when the proposal is finalized.

Information

In the Balanced Budget Act, and both attempts at rulemaking that have ensued, information is seen as

a critical tool for empowering enrollees. Information must be provided on the scope of the benefits covered under the plan, the names and locations of providers, procedures for obtaining covered services, how to access services that are covered under the state's Medicaid program but not available through the enrollee's plan and any cost-sharing that is required. The proposed regulations also specify that enrollees must be given information on "the extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers."

The 'conscience' provision creates a situation in which a woman legally entitled to receive family planning services may be denied even information about where she can get the service out-of-plan.

Information about plan specifics must be provided to Medicaid recipients at key points: when they are choosing among managed care plans and upon their initial enrollment in a plan. Notably, however, while the earlier rule would have required plans to provide that information to enrollees annually, the proposed regulations simply require plans to notify enrollees each year that they have a right to *request* the information. An enrollee who does not regularly request information may therefore not have received it for many years when that information might become relevant.

Exclusions on Religious Or Moral Grounds

The proposed regulations make yet another extremely significant change that involves the information provided to enrollees, this time in the context of the so-called conscience provision. Ironically, this provision, which could have the effect of significantly impeding enrollees' access to needed services, is included in the section of the rules devoted to "enrollee rights."

While Medicaid enrollees are entitled to both full information about their treatment options and access to all Medicaid-covered services, and while the Balanced Budget Act itself explicitly prohibits plans from restricting the information *individual* health care providers may offer patients, the statute also provides that a plan may refuse "to provide, reimburse for, or provide coverage of, *a counseling or referral service* if the organization objects…on moral or religious grounds" (emphasis added). This creates a situation in which a woman legally entitled to receive family planning services may be denied even information about where she can get the service out-of-plan.

To promote enrollees' ability to access the full range of services to which they are entitled, the previous rules had required a plan declining to cover a particular service to, at the very least, tell enrollees that they could obtain information about how to access that service from the state. The proposed regulations would delete that requirement and allow plans to instruct providers to say nothing other than the simple fact that the service is not covered under the plan. By not requiring plans to provide any information at the point of the actual clinical visit, the rules as now proposed have the very real potential to deny patients the precise information they need, at the precise moment they need it most.

Family planning advocates assert that providing this critical information link could be easily accomplished by requiring states to establish toll-free phone numbers through which enrollees would be told how to access the care they seek; plans would need to be required only to provide this phone number whenever an enrollee seeks information about a service that is excluded on religious or moral grounds. In addition, advocates say, this telephone number should be included in the printed materials given by plans to enrollees, alongside the notification that the plan has chosen to exclude some services for religious or moral reasons.

Ironically, in the absence of such requirements, the proposed regulations inadvertently would result in an increase, rather than a decrease, in the burden that would be placed on states. States are responsible both for providing enrollees with the specific information on how to obtain any covered services that plans exclude under the conscience provisions and for ensuring that enrollees have access to all covered services. The state's burden in fulfilling these requirements would be greatly magnified if plans do not, at the very least, direct enrollees to the state to obtain the information they need.

Next Steps

When it announced its new proposal in mid-August, the Bush administration also moved to delay implementation of the previous rules for an additional year, to give it time to finalize its new proposal. While the administration has said that it hopes to be able to complete the process by early next year, advocates are concerned about yet another lengthy delay in implementing the consumer protections that were at the heart of the Balanced Budget Act. After all, they argue, four years have already elapsed since the legislation was signed into law. It is time, they assert, that the safeguards embodied in that legislation be translated into reality for the millions of Medicaid managed care enrollees across the nation.