THE ALAN GUTTMACHER INSTITUTE

Medicaid Support for Family Planning in The Managed Care Era

EXECUTIVE SUMMARY

Managed care has become the organizing principle for Medicaid, the program through which the federal and state governments share the cost of medical care for poor Americans. This report examines key issues related to Medicaid and family planning in this new environment.

The Medicaid Program

- The federal government sets broad parameters for state Medicaid programs, but the states decide who qualifies. Income-eligibility ceilings average 46% of the federal poverty level.
- The 1996 welfare reform law broke the historic link between receipt of welfare and Medicaid eligibility. Although Congress took steps to hold Medicaid eligibility constant, coverage of women of reproductive age declined in the late 1990s.

Medicaid Coverage of Family Planning

- Family planning is one of the few services that federal law requires all state Medicaid programs to cover.
- Medicaid is the largest source of public funds for subsidized family planning services in the United States, contributing roughly half of all public dollars spent.

Medicaid and Managed Care

- In the 1980s, states began to seek permission from the federal government to waive key provisions of the Medicaid statute in order to mandate managed care enrollment and limit participants to providers within a plan's network. By 1999, more than half of Medicaid recipients were enrolled in managed care plans.
- The in-plan provider requirement proved problematic for enrollees who sought confidential services or had long-standing relationships with community-based family planning clinics. As a result, Congress specified that in most cases, enrollees may obtain family planning services from the provider of their choice.

The Balanced Budget Act of 1997

- The Balanced Budget Act of 1997 and federal regulations issued in 2001 to accompany it end the need for states to obtain waivers to mandate managed care enrollment. In return, states must abide by a series of federal standards, which establish that the obligation to ensure access rests with the states.
- Medicaid managed care enrollees must be given detailed information about the plan and about the services that are covered and how to obtain them. Enrollees must be notified of their right to obtain family planning services from the provider of their choice.
- Plans may refuse to cover "counseling and referral" services to which they have a religious or moral objection, but enrollees remain entitled to receive information about all of their medical options and about how to obtain information on excluded services. While plans may refuse to pay for services, they may not interfere with patient-provider communication.
- Managed care enrollees must have direct access—that is, without having to obtain a referral from a primary care provider—to a women's health provider within the plan's network for "routine and preventive health care services."

Looking Ahead

- The regulations implementing the Balanced Budget Act, while issued in final form, have been put on hold in the face of strong opposition from states arguing for greater flexibility. These regulations should be fully and responsibly implemented to ensure that Medicaid will continue to play its critically important role in supporting the provision of family planning services and supplies to poor women.

T H E A L A N G U T T M A C H E R I N S T I T U T E

Medicaid Support for Family Planning in The Managed Care Era

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ACKNOWLEDGMENTS

The authors are grateful to Alina Salganicoff of the Kaiser Commission on Medicaid and the Uninsured for her support and assistance in the preparation of this report and to the following colleagues, who reviewed the manuscript and made many helpful suggestions: Alice Berger, Planned Parenthood of New York City; Katherine Kneer, Planned Parenthood Affiliates of California; Dorothy Mann, Family Planning Council; Ellen Rautenberg, Medical and Health Research Association of New York City; Lois Uttley, MergerWatch; Timothy Westmoreland, formerly of the Health Care Financing Administration, U.S. Department of Health and Human Services; and Jacqueline E. Darroch, Patricia Donovan, Beth Fredrick, Jennifer Frost and Sara Seims, The Alan Guttmacher Institute.

Elizabeth Nash provided important assistance, and Dore Hollander edited the report. Kathleen Randall, Michael Greelish and Judith Rothman were responsible for production and layout.

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ISBN: 0-939253-56-9

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INTRODUCTION

In the 35 years since the joint federal-state Medicaid program was established, it has come to play a crucial role in supporting the provision of family planning services and supplies to poor women. The program is now the largest source of public funds for contraceptive care in the United States. A key question facing policymakers and reproductive health care advocates is how to ensure that Medicaid will be able to continue to play this important role as it becomes increasingly dominated by managed care.

In 1997, the enactment of the federal Balanced Budget Act established the first national standards for Medicaid programs operating in a managed care environment, unifying a patchwork of widely varying state experiments with managed care dating back almost two decades. The following year, the Health Care Financing Administration (HCFA), the federal agency that administers Medicaid, proposed comprehensive regulations to implement the landmark law. After spending more than two years considering roughly 300 comments on the proposal, the Clinton administration promulgated the long-awaited regulations on its last full day in office.

The future of those regulations, which were slated to become effective in April 2001, is uncertain. President Bush imposed a 60-day delay on the implementation of all last-minute Clinton administration actions, postponing implementation of the Medicaid regulations until June. Moreover, the National Governors Association, which has long advocated for increased flexibility in the administration of state Medicaid programs, has called for the rules' reversal. Reversing the regulations would not be easy, since they were published in final form: It would require either an act of Congress or a reopening of the entire rule-making process.

But while it is clear that the debate over a nationwide framework for Medicaid managed care is far from over, it is equally clear that managed care has become the organizing principle for the provision of Medicaid-funded services to eligible indigent women and children in the United States. This report examines key issues related to Medicaid and family planning in this new environment—for enrollees attempting to obtain services to which they are legally entitled, service providers trying to administer the highest-quality care they can to women in need and policymakers seeking to ensure access to necessary health care as broadly as possible at a reasonable cost.

THE MEDICAID PROGRAM

Enacted in 1965, Medicaid finances the provision of health services to eligible Americans deemed too poor to afford care on their own.[1] The federal government sets broad parameters for states' Medicaid programs, and federal legislation requires a limited number of broad categories of services to be covered. However, the program is administered largely by the states, which have the discretion to decide whether to participate at all, what specific services to include and where to set income-eligibility criteria. While nearly all states established Medicaid efforts shortly after the program was launched, Arizona did not fully participate until the 1980s.

The cost of providing care to recipients is shared by the federal and state governments. States are assigned a "federal financial participation" rate, the proportion of the cost of providing services for which they will be reimbursed by the federal government. These rates, which range from 50% to 77% of the cost of services, are inversely related to per capita income in the state, so that less-affluent states are reimbursed at a higher rate.[2]

Although poor elderly and disabled Americans are eligible for Medicaid coverage, one of the program's key original goals was to provide medical care to welfare recipients, in order to encourage independence and, by so doing, help propel them off the welfare rolls and into the workforce. In fact, as the program was designed, welfare eligibility automatically entitled a family to Medicaid coverage. Most states did not have separate eligibility or enrollment procedures for Medicaid. To be eligible for welfare benefits, a family had to meet stringent state-set requirements related to family composition—typically that the family comprised a single parent with dependent children—as well as income-eligibility criteria.

With passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996—so-called welfare reform—Congress fundamentally changed both the nature and the scope of public assistance for poor families. One of the central "reforms" was the repeal of an ongoing entitlement to cash assistance for as long as a family continued to meet the program's income and family structure requirements. As the legislation took shape, health care advocates were concerned that as a result of losing welfare benefits, large numbers of poor families would automatically lose their Medicaid coverage as well.

Responding to these concerns, Congress included a provision aimed at holding Medicaid eligibility constant. An amendment added largely at the behest of the late senator John Chafee (R-RI) provided that families meeting what had been a state's income-eligibility requirements for Medicaid prior to the legislation will be eligible in the future, regardless of whether

they qualify for welfare. (These income levels, which range from 15% of the federal poverty level in Alabama to 86% of poverty in California, average 46% of poverty nationwide.[3] The federal poverty level in 2001 is $14,630 for a family of three.[4]) This provision, which effectively delinked eligibility for Medicaid from eligibility for welfare, both ensured that families already enrolled in Medicaid would continue to be covered and permitted additional families to enroll even if they did not qualify for welfare under the new rules.

While it is still too early to assess the responsibility of welfare reform, it is clear that since the enactment of the 1996 legislation—and despite the best intentions of the Chafee amendment—both the number and the proportion of American women of reproductive age covered under Medicaid have fallen dramatically. Between 1994 and 1999, this proportion fell by nearly one-quarter—from 13% to 10%.[5] In 1998, Medicaid covered only one-third of all poor adult women in the United States.[6] Data for 1999, however, show that adult enrollment may be stabilizing.[7]

MEDICAID COVERAGE OF FAMILY PLANNING

Over the 35 years of Medicaid's history, the program's coverage of family planning services and supplies has undergone an extraordinary transformation. When the program was first established, each state was permitted to decide whether even to cover family planning. Currently, coverage is mandated for all states; moreover, states may claim preferential reimbursement from the federal government for the amount they spend to provide family planning services and supplies to enrollees.

Early Gaps in Coverage Began to Close in the 1970s

While most states voluntarily included family planning services in their early Medicaid efforts, important gaps remained.[8] Nine of the 48 states participating in Medicaid in 1970 did not cover family planning at all. Other states provided only limited access. Florida and Oregon, for example, required that enrollees seeking family planning services first obtain authorization from the local welfare agency. North Dakota required enrollees seeking prescription drugs—including oral contraceptives—to obtain prior authorization. Kentucky and Missouri covered contraceptive drugs, but not "birth control devices."

Medicaid coverage of family planning changed dramatically in the early 1970s. One key reason is that evidence began to emerge that unintended childbearing—especially among teenagers—could have serious social and economic consequences, including increased poverty and reliance on public assistance. Another was a growing perception that repeated, closely spaced births or childbearing very early or late in the reproductive years could lead to adverse health outcomes for both mothers and their children.[9]

Family Planning Has Long Had Special Status in the Medicaid Program

As part of omnibus amendments to the Social Security Act in 1972, Congress expanded the benefits package required of all state Medicaid programs 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."[10] This move established a legal entitlement to family planning for Medicaid recipients nationwide.

As additional encouragement to states to make family planning services accessible to program recipients, Congress at the same time established a special reimbursement rate of 90% for family planning services and supplies.[11] Given that some states could claim federal reimbursement for only 50% of the costs of providing other medical services, this rate offered a clear advantage to the states.

A medical procedure can be considered family planning only if its primary purpose is to prevent pregnancy.

Federal law also prohibited states from charging fees for Medicaid-covered family planning services and supplies.[12] This prohibition continues today,[13] despite some indication that it is not being adhered to universally.*

Despite Its Special Status, "Family Planning" Has Never Been Precisely Defined

Although family planning has repeatedly been afforded advantageous treatment under Medicaid, the term has never been precisely defined for purposes of the program. This lack of definition was not necessarily intentional. Three times during the 1970s, the Department of Health, Education and Welfare—the predecessor to the Department of Health and Human Services (DHHS)—proposed rules that would have defined family planning services. However, none of these rules were finalized, largely because of disagreements over whether abortion and sterilization should be included.† As a result, the specific services for which this special reimbursement rate is available have remained ambiguous.

In the absence of formal regulations, HCFA has developed a set of guidelines, which have become a de facto definition for the program. According to HCFA, states may claim federal reimbursement for 90% of the costs of "counseling services and patient education, examination and treatment by medical professionals in accordance with applicable State requirements, laboratory examinations and tests, medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception, and infertility services, including sterilization reversals." Within these broad guidelines, states "are free to determine the specific services and supplies which will be covered as Medicaid family planning services."[14]

Under the HCFA guidelines, services must be "expected to achieve a family planning purpose" in order to be reimbursed at the 90% rate. Tests to screen for sexually transmitted diseases (STDs), for example, are covered at 90% "when performed routinely as part of an initial or regular or follow-up visit/examination for family planning." However, "if a routinely performed screening test indicates that the patient has a medical condition/problem which requires treatment," the treatment is not covered at the preferential rate.[15]

*In a 1996 study of 27 Medicaid managed care plans in five states, two plans reported requiring a copayment for family planning. Nine percent of Medicaid managed care enrollees reported having been charged fees for contraceptive services, and 3% indicated that they had discontinued use of a contraceptive method because of the cost. (Source: Gold RB, Darroch JE and Frost JJ, Mainstreaming contraceptive services in managed care, *Family Planning Perspectives*, 1998, 30(5):204–212.)

†Regulations proposed in 1973 appeared to include abortion in the definition of family planning services, but were silent on sterilization (source: *Federal Register*, 1973, 38(118):15580–15585). Regulations proposed in 1974 made clear that abortion was excluded from the definition but that sterilization was included (source: *Federal Register*, 1974, 39(237):42919–42920). Regulations proposed in 1979 would have included sterilization but excluded abortion (source: *Federal Register*, 1979, 44(15):46899–46901).

HCFA has also indicated that a medical procedure can be considered family planning only if its primary purpose is to prevent pregnancy. For example, if a woman's ovaries are removed because of extensive endometriosis, the procedure cannot be claimed as family planning, even though the result is that the woman will not be able to become pregnant.[16] A sterilization performed primarily for family planning purposes is within the definition, although a sterilization performed for the treatment of a medical condition is not.* Similarly, a diagnosis of infertility would usually result in infertility services' being covered at the 90% rate. Almost all states seek 90% federal reimbursement for at least some services that they define as family planning.[17]

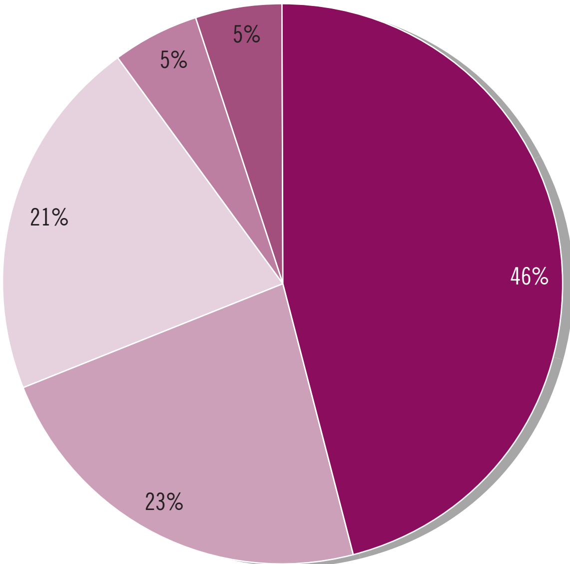
Abortion "may not be claimed as a family planning service."[18] However, federal law allows abortion services to be covered under Medicaid when the woman's life would be endangered if the pregnancy were carried to term and in cases of rape or incest.[19] Furthermore, individual states remain free to use their own funds to pay for abortions for Medicaid recipients, and 16 do so.[20]

*In 1978, the Department of Health, Education and Welfare promulgated regulations to govern the availability of federally funded sterilizations. The rules specify a procedure for obtaining a woman's informed consent, a 30-day waiting period and a prohibition against sterilizing anyone who is younger than 21 or is mentally incompetent.

The lack of an overall national definition of family planning services has led to modest variations across state programs.[21] Responses to a survey conducted in 2000 illustrate these variations.[22] Forty-seven states and the District of Columbia said that they covered all currently approved prescription methods of contraception (oral contraceptives, IUDs, implants and injectables), although only 27 states and the District of Columbia covered emergency contraception. Alabama covered medical procedures associated with a contraceptive method (such as an IUD insertion), but not the actual method. Only 32 states and the District of Columbia covered over-the-counter contraceptives, such as condoms, spermicides and sponges. Almost all jurisdictions indicated that they covered testing for and treatment of STDs, although these services are not always considered family planning.

Medicaid Makes a Vital Contribution to Publicly Funded Family Planning Services

Family planning services are funded through a number of widely differing public programs. The major sources of federal support are Medicaid, Title X of the Public Health Service Act—the only federal program focused solely on the provision of family planning—and, to a lesser extent, the social services and maternal and child health block grants.[23] Two newer federal programs, Temporary Assistance to Needy Families and the State Children's Health Insurance Program, are also becoming impor-



Public expenditures, FY 1994 ($715 million)

Figure 1 Medicaid contributes one of every two public dollars spent for family planning in the United States.

- Medicaid
- State contributions
- Title X
- Maternal and child health block grant
- Social services block grant

Source: reference 24.

tant sources of federal support for family planning.* In addition, most states use their own revenues to subsidize family planning services and supplies.

It would be difficult to overstate the importance of Medicaid to the provision of publicly funded family planning services and supplies in the United States. In 1994, the most recent year for which data are available, a total of $715 million in federal and state funds was spent to provide contraceptive services and supplies in the United States. Medicaid was the largest source of public funding for contraceptive services and supplies nationwide, providing 46% of all public dollars spent. States provided the second-largest share, contributing 23% of the funds (Figure 1).[24]

Medicaid's role as a funding source has expanded greatly over time. In 1980, the program contributed one out of every five public dollars spent for contraceptive services and supplies. By the early 1990s, Medicaid was contributing one out of

*Under the State Children's Health Insurance Program, states have three options: expanding Medicaid; using a separate, state-designed program; or employing a combination of approaches. Under federal law, enrollees in Medicaid expansion programs or in Medicaid components of combination programs are considered Medicaid enrollees and are entitled to the same services as are other Medicaid enrollees. Most often, services are delivered through managed care plans.

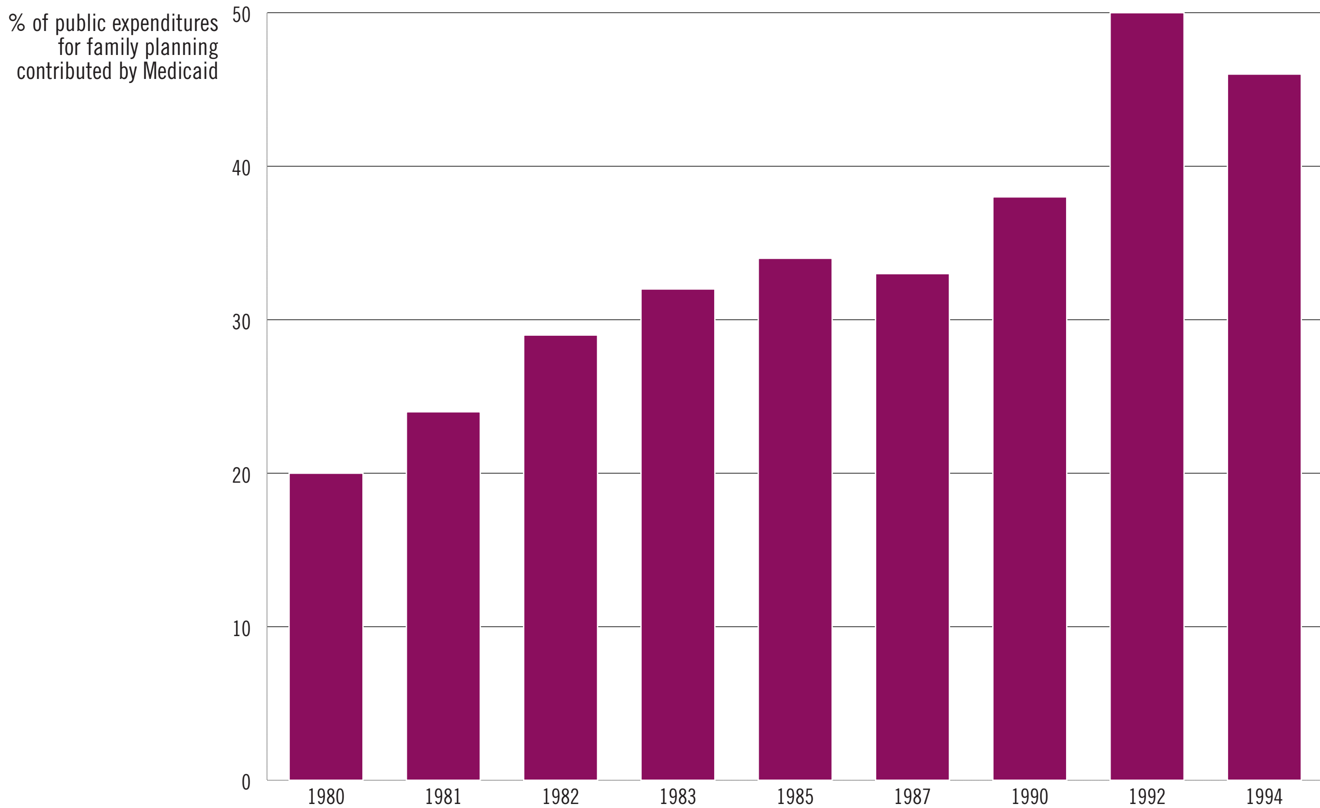


Figure 2 The contribution of Medicaid to public funding of family planning has increased dramatically.

Source: reference 25.

every two public dollars (Figure 2).*[25]

The growth in the importance of Medicaid as a funding source for family planning heightens the significance of major changes that are made to the program. The recent move of Medicaid, along with health care generally, to a managed care model has important implications for the recipients and providers of publicly subsidized family planning services and supplies.

*The proportion contributed by Medicaid appears to have slipped slightly from 1992 to 1994. However, that apparent decline may reflect reporting problems resulting from widespread enrollment in capitated managed care systems, rather than an actual decrease in coverage. A method for accurately tracking the level of Medicaid expenditures for family planning services and supplies in managed care environments is vitally needed.

MEDICAID AND MANAGED CARE

Over the last 15 years, managed care has become the organizing principle for the Medicaid program, a development that poses challenges for both Medicaid recipients in need of family planning and providers seeking to meet that need. An underlying principle of managed care—that enrollees obtain services from a specified network of providers—has proven particularly problematic. While Congress has moved to allow enrollees to obtain family planning services from the provider of their choice, including providers outside their plan's network, implementation of this important provision has been difficult.

Policymakers Have Looked to Managed Care to Control Costs Without Compromising Quality

Managed care is not new to the American health care marketplace; its origins can be traced to the labor cooperatives of the 1930s and the tradition of having company doctors care for employees and their dependents. But in the 1990s—with health care costs spiraling upward and managed care promising to deliver quality, coordinated care while controlling costs—decision-makers in both the private and the public sectors came to view it as something of a panacea. As a result, managed care has exploded on the health care scene, in both arenas.

Yet a managed care model of health care service delivery, which limits enrollees to a specific network of providers, is incompatible with the Medicaid statute. When the program was established, its framers were concerned about the proliferation of so-called Medicaid mills that would provide inferior care to a poor and politically disenfranchised clientele. As a result, policymakers employed a variety of strategies to promote the provision of high-quality care, chief among which was a requirement that Medicaid enrollees be free to obtain care from the provider of their choice. This "freedom-of-choice" provision was based on the premise that if Medicaid recipients could go to the same providers as more affluent Americans, they would obtain higher-quality care than they would get from providers serving exclusively low-income populations. The Medicaid statute addressed this conflict by allowing states to develop managed care programs under which enrollees would voluntarily relinquish their freedom of provider choice but preventing states from making managed care enrollment mandatory.

Federal Waivers Have Spurred Rapid Increases in Medicaid Managed Care

The situation changed with the passage of the Omnibus Budget Reconciliation Act of 1981, which allowed states to ask HCFA for permission to waive the freedom-of-choice principle either statewide or for specified areas. These "1915 waivers" (named after the section of the Medicaid statute authorizing them) permitted states to make managed care enrollment mandatory for Medicaid recipients and opened the floodgates

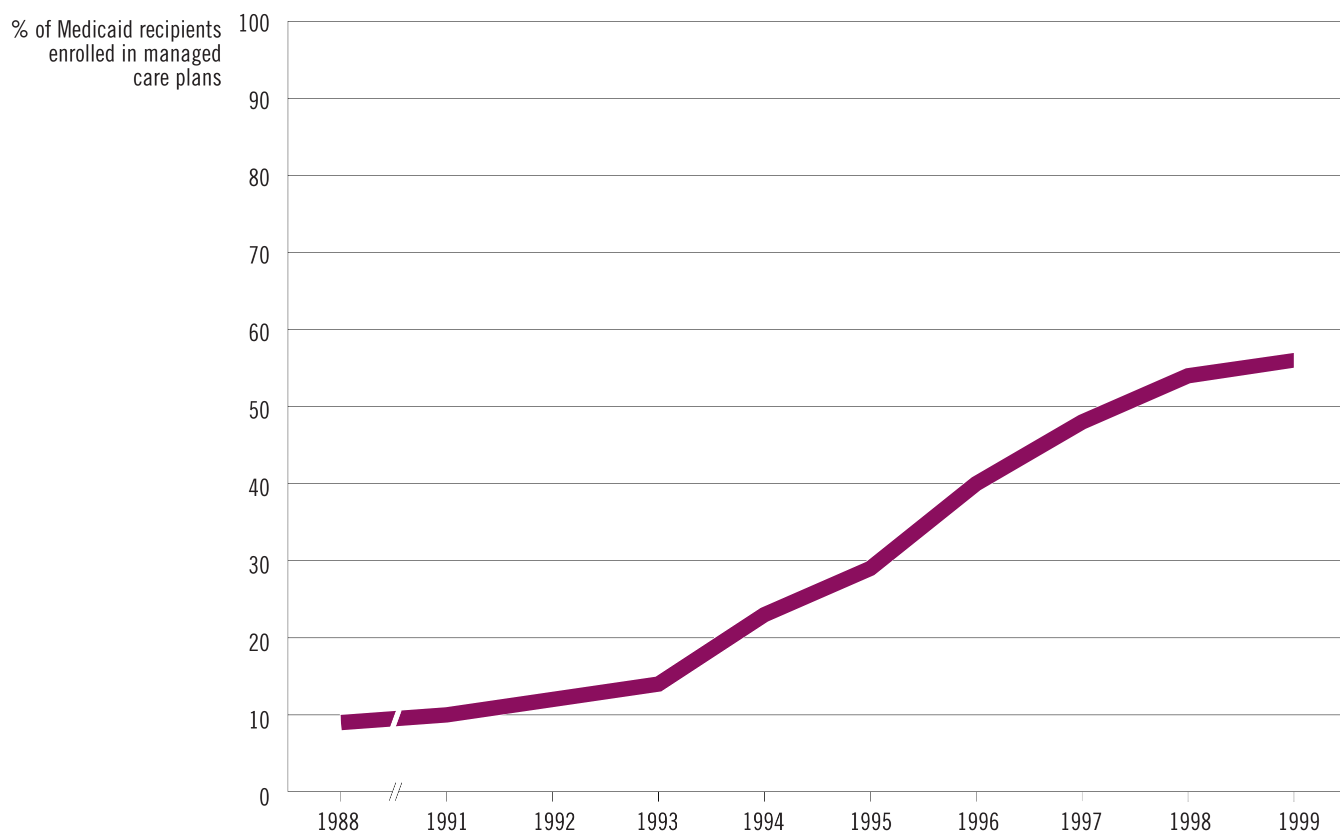


Figure 3 Medicaid managed care enrollment has climbed sharply in the past decade.

Source: reference 29.

for Medicaid managed care enrollment. In 2001, 29 states and the District of Columbia are using 1915 waivers to enroll at least some Medicaid recipients in managed care programs.[26]

Fifteen states are using a separate provision of federal law, the so-called 1115 research and demonstration waivers, to make more dramatic changes to their Medicaid programs.[27] Under these waivers, states often alter the benefits package or broaden eligibility criteria to include individuals who would not have qualified; almost all applications for these waivers include mandatory managed care.

In contrast to the more streamlined process for obtaining a 1915 waiver, the process for obtaining a waiver under section 1115 requires that the state submit a detailed application to HCFA, setting forth the program's operation and an evaluation plan. HCFA carefully reviews each waiver application and almost always imposes special terms and conditions for waivers that it approves. As a result, the federal requirements and the waiver programs vary, sometimes dramatically, from state to state.

Spurred on by the twin promises of cost containment and high-quality care—and through the use of these two federal waiver authorities—Medicaid managed care enrollment has skyrocketed. The number of enrollees grew from 2.7 million in 1991

While the retention of freedom of choice under section 1915 is critical to preserving access to Medicaid-funded family planning services for many enrollees, it is neither a comprehensive nor a simple solution.

to 17.8 million in 1999.[28] All states except Wyoming and Alaska have some Medicaid managed care enrollees.

While fewer than one in 10 Medicaid recipients were enrolled in managed care plans in 1988, more than half were enrolled by the late 1990s (Figure 3).[29] In 1999, at least one in four Medicaid recipients in 43 states and the District of Columbia were enrolled in managed care programs; in 13 states, the proportion was more than three in four.[30]

Significantly, not all Medicaid enrollees are equally likely to be enrolled in managed care plans. The elderly and the disabled, who make up nearly one-third of Medicaid recipients nationwide,[31] are less likely than younger people and those without disabilities to be in managed care arrangements. Poor women and their dependents, who are the population likely to be in need of family planning services and supplies, are the most likely to be enrolled in managed care plans. By the end of the 1990s, the majority of poor women and children receiving Medicaid obtained their care through managed care plans.

Federal Law Retains Enrollees' Right to Freedom of Choice for Family Planning

As Medicaid enrollment in managed care plans began to grow in the 1980s, problems surfaced for both enrollees seeking family planning services and the network of community-based agencies that had traditionally provided these services. Enrollees continued to seek care from community-based providers—even when the providers were not affiliated with the enrollees' managed care plans—for many reasons, including "the need for confidentiality, patient preference and comfort, and the need to avoid service delays imposed by the managed care system."[32] As a result, community-based providers increasingly found themselves having to either send these clients back to their health plans or provide services without reimbursement, a practice that diverts scarce grant revenues intended to subsidize care for uninsured clients.

In 1986, Congress amended section 1915 to provide that while states may seek federal waivers of enrollees' freedom of choice for all other Medicaid-covered services, they may not do so with respect to family planning.[33] As a result of this amendment, a Medicaid recipient who is enrolled in a managed care plan may obtain Medicaid-covered family planning services from the provider of her choice, regardless of whether that provider is part of the plan's network.

But while the retention of freedom of choice under section 1915 is critical to preserving access to Medicaid-funded family planning services for many enrollees, it is neither a comprehensive nor a simple solution to problems with access to family planning in Medicaid managed care. Programs operat-

ing under the authority of 1115 waivers remain legally free to limit enrollees seeking family planning services to the plan's network of providers. (Significantly, however, 11 of the 16 states that were operating programs under 1115 waivers in 1998 voluntarily provided freedom of choice for managed care enrollees obtaining family planning.[34]) Furthermore, because key decisions are left to the discretion of each state, important differences remain in implementation and impact.

The Freedom-of-Choice Provisions Have Been Difficult to Implement

One of the chief difficulties that has arisen in implementing the retention of freedom of choice for family planning stems from the narrow scope of services that may be covered. A concern frequently cited by family planning providers is that they may be reimbursed for the diagnosis of an STD or a urinary tract infection but not for treatment, because such treatment is not considered "family planning." Similarly, Medicaid may reimburse them for providing a Pap test to a managed care enrollee seeking care outside her plan's network, but not for following up with that patient in the event of an abnormal test result. In those instances, family planning providers report that they generally "just go ahead and treat" the patient—even in the absence of Medicaid payment—because they cannot justify sending a woman back to a provider whom she chose not to go to in the first place.[35]

A second key problem stems from the mechanisms by which out-of-plan family planning providers are accommodated by the system. In 1995, approximately two-thirds of family planning agencies that served Medicaid managed care enrollees out of plan billed the state Medicaid agency—an arrangement that may work well—but the remaining one-third were left to seek reimbursement from managed care plans with which they had no contractual relationship.[36] Of Medicaid agencies surveyed in 2000, about half paid providers directly, while the other half required clinics to obtain reimbursement from the managed care plans; of the latter group, only half required plans to pay providers within a specified time period.[37]

In many cases, providers seeking payment from a managed care plan in the absence of a contract go unpaid.[38] The result is that some family planning agencies do not even try to secure reimbursement and instead absorb the cost of the care provided.[39] This places a drain on their budgets and forces them to pay for Medicaid enrollees' care with scare public dollars that were intended to finance services for uninsured clients.

A third major problem involves the extent to which managed care enrollees are informed, by either the Medicaid agency or the managed care plan, that they may have the freedom to choose their provider of family planning services and may obtain care from a provider outside the plan's network. For

For all of its imperfections and implementation problems, the principle of freedom of choice for family planning has provided vital access to women covered by Medicaid.

example, a study of managed care enrollees in New York State found widespread communication problems, with women often indicating that they were not informed of the freedom-of-choice option.[40]

Yet, for all of its imperfections and implementation problems, the principle of freedom of choice for family planning has provided vital access to women covered by Medicaid who might otherwise have been unwilling or unable to obtain care. Studies of women obtaining out-of-network care from family planning providers in California and New York in the mid-1990s found that women chose these clinics rather than network providers primarily because of their familiarity, privacy, confidentiality, wider array of methods, more convenient services and shorter waiting times for appointments.[41]

In a 1996 study of managed care in five areas with relatively mature managed care environments, The Alan Guttmacher Institute (AGI) found that one in 10 Medicaid managed care enrollees who made a visit for contraceptive services used a provider not affiliated with her plan.* Furthermore, four in 10 community-based family planning providers in the study areas reported serving Medicaid managed care enrollees out of plan.[42]

Over Time, the States Pressed for an Alternative to Waivers

While appreciating the flexibility to design their own managed care efforts, the states eventually began to chafe at the need to go through the cumbersome waiver process. Instead, they pressed for the ability to mandate Medicaid recipients' enrollment in managed care without the need to seek and obtain a waiver from the federal government. This tension played out with the passage by Congress of the Balanced Budget Act of 1997.

*The study included all of Colorado, Massachusetts and Michigan, as well as selected counties in California and Florida. In each of these areas, AGI asked all managed care organizations serving commercial or Medicaid enrollees about their coverage of contraceptive services and the procedures for obtaining that care. Additionally, all publicly funded family planning agencies were queried about their involvement with managed care plans, and representative samples of reproductive-age women who were at risk of unintended pregnancy and enrolled in managed care plans were asked about their plan's coverage and their experiences in obtaining contraceptive services.

THE BALANCED BUDGET ACT OF 1997

At the heart of the Balanced Budget Act of 1997 lies a bargain between the federal government and the states. The federal government, for its part, will allow states to mandate enrollment in managed care plans without obtaining a waiver. In return, states must abide by a series of federal requirements governing their Medicaid managed care efforts (see box, page 18).*

Little in the act is specific to family planning. Nevertheless, several provisions of the law and the accompanying regulations that are currently in abeyance have dramatic—and generally very positive—implications for the delivery and accessibility of family planning services in Medicaid managed care environments.†

The Act Clarifies Enrollees' Right to All Covered Services

The Balanced Budget Act leaves undisturbed the central provisions underlying the federal Medicaid statute, which entitle all Medicaid recipients to receive all care covered by the program. States may transfer this obligation to managed care plans by way of a contract under which states pay plans to provide enrollees with a range of covered services.

Most states appear to have taken this route with respect to family planning. A review of Medicaid managed care contracts in 38 states and the District of Columbia showed that the majority included coverage of family planning services. However, while some contracts were very specific about the package of specific services included, others were quite general.[43]

The Balanced Budget Act requires managed care plans to "offer an appropriate range of services and access to preventive and primary care services for the population expected to be enrolled"[44] and to guarantee that "covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialized services capacity."[45] It also bars states from entering into a contract with a managed care plan that "fails substantially to provide medically necessary items and services that are required…to be provided to an enrollee covered under the contract."[46]

The regulations elaborate on these general points. Under the rules, it is the state's responsibility to "ensure that all covered services are available and accessible to enrollees."[47] Plans con-

*If they chose, however, states could continue to operate their waiver programs, and even apply for new waivers; states taking this route would not be required to adhere to the uniform federal standards imposed by the Balanced Budget Act.

†Some provisions of the regulations—generally, those concerning access to care within a managed care plan—do not apply to primary care case management systems, which combine some characteristics of managed care and some characteristics of a fee-for-service system. In 1999, 60 primary care case management plans provided care to about one in five Medicaid managed care enrollees (source: HCFA, Medicaid managed care enrollment report, 1999, <http://www.hcfa.gov/medicaid/omc1999.htm>, accessed Jan. 31, 2001).

General Requirements of the Balanced Budget Act

Among the Balanced Budget Act's key requirements for Medicaid managed care efforts are the following:

- *Enrollees must have a choice of managed care plans, except in rural areas.*
- *Enrollees must be permitted to change plans at least once a year.*
- *Enrollees must be provided with detailed information about the benefits that are covered and how to obtain covered services.*
- *Managed care plans must include a sufficient number and mix of providers in their networks to ensure that enrollees have adequate access to covered services.*
- *Plans' marketing activities must facilitate informed decision-making.*
- *Plans must cover emergency care when the symptoms "are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson."*
- *Plans may not limit provider-patient communication.*
- *A series of protections against fraud and abuse must be imposed.*
- *A comprehensive quality assurance system must be established that includes provisions on access, clinical quality, consumer grievances and other indicators of quality, while requiring external review of the quality of care.*

tracting with the state to provide care to Medicaid managed care enrollees must show that they maintain "a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of enrollees in the service area."[48] If a plan is unable to provide adequate access to any covered service within its network, enrollees must be allowed to obtain that care from a provider outside the network at no additional out-of-pocket cost, and the plan must reimburse the provider.[49]

The preamble to the regulations states that this provision is specifically intended to apply when a network provider decides that the enrollee needs care that is not available within the network but is related to a covered service.[50] The example that HCFA used to illustrate this situation is a tubal ligation following a cesarean delivery. In citing this example, the agency made a clear—but unspoken—attempt to get at the problem posed by the refusal of some religious plans or providers to cover sterilization.

States are not required to enter into contractual relationships with managed care plans to provide all Medicaid-covered services to enrollees; some services may be kept outside the purview of a managed care contract entirely. For services that are covered under a state's Medicaid program, but not under a specific managed care contract, the regulations put the burden

When a service is covered by a contract, the plan has the obligation to provide reasonable access; when a service is not included in a contract, the obligation to ensure access remains with the state.

of ensuring access directly on the state agency: "The State must make those services available from other sources and provide to enrollees information on where and how to obtain them, including how transportation is provided."[51]

These standards are aimed at ensuring access to all Medicaid-covered services—including family planning—regardless of whether they are included in a managed care contract. They establish a basic principle: When a service is covered by a contract, the plan has the obligation to provide reasonable access; when a service is not included in a contract, the obligation to ensure access remains with the state.

Plans May Opt Out of Covering Counseling and Referral Services on Religious or Moral Grounds

Federal and state law have long permitted individual and institutional health care providers to decline to provide abortion or sterilization services if doing so would be against their religious beliefs or moral convictions. Several states also permit providers to refuse to participate in, or even provide information about, family planning services in general.[52] Managed care has exponentially expanded the potential impact of these so-called conscience opt-outs. By limiting the providers from whom an enrollee can obtain care, it has heightened the significance of the refusal of an individual or institution to provide services, at least for Medicaid enrollees.

In addition, managed care has blurred the once-sharp line between those who provide care and those who pay for it. This change has led to questions about whether entities such as managed care plans should be entitled to claim a corporate "conscience" and opt out of paying for any health care service that may be against the "beliefs" of their board of directors.

The Balanced Budget Act gave plans a major boost in this regard, with its wide-ranging provision allowing any Medicaid managed care plan (whether or not religiously controlled, or even affiliated) to opt out under certain circumstances. This provision gives plans the right to object and refuse "to provide, reimburse for, or provide coverage of a counseling or referral service if the organization objects to the provision of such service on moral or religious grounds."[53] Significantly, this provision does not affect the long-standing entitlement of all Medicaid recipients to all Medicaid-covered services, including those to which an individual managed care plan may object. The regulations attempt to implement that provision by establishing a set of principles that are designed to provide this opt-out for plans while maintaining enrollees' ability to obtain the care to which they are legally entitled.

Notably, the discussion of the issue in the preamble to the regulations begins with a statement on the rights of enrollees, saying that they "are entitled to receive from their health care

When a Plan Opts Out

Fidelis Care is a managed care plan sponsored by Roman Catholic dioceses and hospitals in New York State. It has more than 100,000 enrollees statewide, most of them Medicaid recipients. Citing the Church's Ethical and Religious Directives for Catholic Health Care Services, *Fidelis refuses to provide or make direct referrals to other providers for contraceptive services, sterilization or abortion.*[1]

Instead of requiring Fidelis to provide family planning services to Medicaid recipients through one of the third-party arrangements common in other states, New York officials decided to rely on existing provisions allowing freedom of choice for family planning services. State guidelines require Fidelis to inform enrollees and prospective enrollees that family planning services are available from any provider who accepts Medicaid, that no referral is required to obtain these services and that there will be no cost to the enrollee. (This information must be included in the plan's marketing materials and member handbook, and provided orally at the time of enrollment.) Nonetheless, early reviews of the situation seemed to indicate that these provisions were insufficient, and that "confusion and misinformation about the free access policy [were] the rule rather than the exception."[2]

Reproductive health care advocates remain particularly concerned about the impact of the Fidelis policy on teenagers, who may be unlikely to receive the materials on the freedom-of-choice provision or to know that they are entitled to go outside their plan for family planning services and supplies. Like many managed care plans nationwide, Fidelis sends its information for enrollees to the head of the household, and not to dependents who are also covered by the plan.

Advocates are further concerned that because the organization's name is not explicitly religious, potential enrollees will not realize that the plan has a Church affiliation and therefore limits its services. In addition, some Medicaid recipients are automatically enrolled in the plan if they do not choose a plan within a time frame specified by the state; they, too, may unexpectedly find that their plan does not offer particular services.

To address these concerns, the state has been working to develop a public information campaign, including printed materials along with a media campaign, in various parts of the state. Whether these efforts will be sufficient to overcome the obstacles posed by the Fidelis policy remains to be seen.

References: see page 28.

providers the full range of medical advice and counseling that is appropriate for their condition."[54] Enrollees may leave a plan at any time because its religious beliefs or moral convictions preclude it from covering services they need, including related services (such as a tubal ligation performed after a cesarean delivery).[55]

Moreover, the regulations clarify that while plans may opt out of covering counseling or referral services to which they object, they may not "prevent a physician from giving counseling if the physician is willing to forgo any payment that may be associated."[56] Further, a plan may not block a provider from "advocating" on behalf of a patient. Plans that interfere with communication between patients and providers are open to financial sanction by the state. In other words, plans may choose not to cover a counseling or referral service, but patients are nonetheless entitled to full information about all of their treatment options, and individual providers are entitled to supply that information and advocate on patients' behalf.

A plan choosing to avail itself of the "conscience" option is obligated to inform enrollees, potential enrollees and the state of its decision. Further, the plan must tell enrollees where and how to obtain *information* about services it will not cover, but unfortunately is under no obligation to tell them where and how to obtain the *care.* That responsibility falls to the state.[57]

Arm's-Length Arrangements

Different administrative models result in the creation of different arm's-length arrangements for providing access to family planning services for Medicaid recipients enrolled in Catholic managed care plans.[1] For example, in Arizona, where the state requires all health plans with which it contracts to provide access to family planning services, the Catholic Mercy Care Plan subcontracted with an administrative agency, Kachina Administrative Services, to arrange and pay for family planning for Mercy Care members. The state separates out the funds to be used for family planning and sends those funds directly to Kachina; Mercy never "touches" the money. Kachina, for its part, contracts independently with most of Mercy's primary care and obstetric providers for family planning services; these providers then bill Kachina, rather than Mercy, for the family planning services they provide. From the enrollees' perspective, this bifurcated system is largely invisible. For the most part, women obtain family planning services from the same providers whom they see for their other care.

An arrangement in Pennsylvania takes a different approach, by using an existing network of family planning clinics to provide services. This arrangement also grew out of a state requirement, in this case a statute mandating that plans "have arrangements with other providers for referring recipients for services for which they are eligible under the Medicaid Assistance Program but which are not provided" directly by the plan.[2]

Two commercial plans in the Philadelphia area—the Catholic Mercy Health System and Keystone Health Plan East, a nonsectarian Blue Cross/Blue Shield plan—joined together to form Keystone/Mercy Health Plan to serve Medicaid recipients, although they remain separate for other purposes. The member handbook for the joint Medicaid plan explicitly states that a Keystone/Mercy doctor cannot provide family planning and sterilization services. Instead, those services are available through Keystone, which contracts with the Family Planning Council in Philadelphia to provide Keystone/Mercy's enrollees access to confidential care at 88 family planning clinic sites throughout the service area. Enrollees may either go to the clinics directly or call Keystone for help in locating a clinic.

References: see page 28.

Ensuring access to care for enrollees when a plan opts out for religious reasons can be a challenge. New York State confronted such a situation when it signed a contract with a Catholic Church–sponsored plan that did not include coverage of family planning services (see box, page 20). Although the state has taken several steps to afford access to family planning—including developing guidelines and an outreach and education campaign—the results so far have been mixed.

At the same time, a study by Catholics for a Free Choice found that in 2000, only 15 of 48 Catholic managed care plans nationwide served Medicaid recipients. Thirteen of these 15 plans had found a way to provide access to some family planning services for enrollees, often because their states required that managed care plans seeking to obtain a Medicaid contract provide the full range of benefits covered by Medicaid in the state. Many of these 13 plans have used creative "arm's-length" arrangements to provide the required services (see box). Only two plans, including the one in New York, failed to make any provisions for covering family planning services.[58]

The Balanced Budget Act Retains Freedom of Choice for Family Planning

While the Balanced Budget Act repealed the provision requiring states to obtain a federal waiver in order to mandate enrollment in managed care plans, it did not repeal the provision

The provision of information to Medicaid managed care enrollees is one of the key elements of the Balanced Budget Act standards.

guaranteeing freedom of choice for managed care enrollees seeking family planning. Indeed, the regulations explicitly state that Medicaid law, as amended by the Balanced Budget Act, "permits a State to restrict the freedom of choice…for all services except family planning services."[59] The rules also require that enrollees be notified of their right to obtain family planning services from the provider of their choice, whether inside or outside the plan's network.[60]

The law and the regulations are less clear, however, on a related issue aimed at facilitating Medicaid managed care enrollees' access to women's health care providers within the plan: direct access. Here, the question is whether enrollees must obtain a referral from a primary care provider before seeking family planning services from another network provider. The legislation itself is silent on the issue. As the Clinton administration was developing the regulations, it also was considering ways to extend the reach of a package of protections for managed care enrollees, known as the Consumers' Bill of Rights and Responsibilities, which features direct access to women's health care as one of its centerpieces.

In line with that effort, the regulations require direct access for "routine and preventive health services" for women. That phrase is not defined in the rule itself, but the preamble says that it is intended to mean "initial and follow-up visits for services unique to women, *such as* prenatal care, mammograms, pap smears, and for services to treat genito-urinary conditions…and sexually transmitted diseases" (emphasis added).[61] The use of a limited set of examples may cause confusion at the state level about how to implement the provision and about the specific set of services for which direct access should be provided within plans. The preamble is much more precise in listing the types of providers from whom services are directly available, specifically including certified nurse-midwives and nurse practitioners, as well as gynecologists.[62]

Access to family planning services within Medicaid managed care plans has been a significant problem. All 27 plans that AGI examined in its five-state study required the enrollee to designate (or else be assigned) a primary care provider.[63] Nine of the plans made no provisions for direct access to gynecologic services in addition to the services available from the woman's primary care provider.[64]

However, some plans provided enrollees with important alternatives to involving their primary care provider. Of the 14 that generally required a referral for contraceptive services, five allowed enrollees to obtain that referral on a confidential basis directly from the plan, rather than having to involve a primary care provider. Fifteen of 17 plans that allowed direct access to at least some contraceptive services honored requests that a

woman's primary care provider not be notified of services obtained through direct access to another caregiver.[65]

Medicaid Managed Care Enrollees Are Entitled to Detailed Information About Their Plan

The provision of information to Medicaid managed care enrollees is one of the key elements of the Balanced Budget Act standards. The legislation requires that states, either directly or through managed care plans, provide enrollees with a range of information, including the benefits covered by the plan and any cost-sharing that is required. Enrollees must also be given specific information on any services that are covered by Medicaid but not available through the managed care plan, including information on how enrollees may access the care.[66] All information is to be provided annually and "upon request," and must be in a form that "may be easily understood by enrollees and potential enrollees."[67]

More specific requirements are in the regulations. For example, the regulations specify that prospective plan enrollees must be given materials that discuss benefits that are covered by Medicaid in the state but are not provided by the plan (i.e., not included in the plan's contract with the state). The regulations specifically require marketing materials to tell potential enrollees how and where to obtain these services, any cost-sharing requirements and how transportation is provided. However, if a service is not covered because of a plan's religious or moral objection, the plan is required only to tell potential enrollees how to obtain information about the service; the *state* is obligated to provide information on how to obtain the service.[68]

The regulations also detail the information that must be provided to managed care enrollees when they join a plan, at least once a year thereafter and within 90 days of when a plan changes its policy. Enrollees must be given information on

- covered benefits;
- enrollee rights (including the right to information about all available treatment options and alternatives);
- procedures for obtaining benefits, including any authorization requirements;
- restrictions on enrollees' ability to choose among network providers;
- "the extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers";[69]
- the plan's policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider;
- cost-sharing requirements; and
- benefits that are covered under the state Medicaid program but are not provided by the plan (again, with the caveat

Recent political events have put the future of the regulations in question.

about information on services excluded because of the conscience exception).

AGI's study of managed care in five states highlights the urgent need for these requirements. According to that study, many Medicaid managed care plans fail to provide enrollees with even basic information about their coverage for family planning services and supplies.[70] Only nine of the plans in the study reported providing information on the specific contraceptive services covered, and only four said that they provide information on the conditions for which testing for HIV or other STDs is provided; only one reported routinely informing enrollees that some participating providers may not provide or refer for all covered services because of religious or moral reasons.[71]

Plans were also unlikely to provide information to dependents. No more than eight reported that they provide information directly to spouses or other dependents aged 18 or older; only six provide information directly to dependents younger than 18. Not surprisingly, women enrolled in managed care plans through their parents were less likely than those with their own coverage to have received any written information on their plan's contraceptive coverage.[72]

Among all women enrolled in the managed care plans studied, seven in 10 reported that they did not receive written information about their plan's contraceptive coverage, even though all the plans covered contraception. Among Medicaid enrollees, 17% did not know whether their plan covered oral contraceptives—the most commonly used contraceptive method in the United States—and 43–60% were unsure about whether their plan covered other reversible contraceptive methods. Only 4% of Medicaid enrollees identified plan materials or brochures as their primary source of information about its coverage of contraceptive services.

These findings underscore the importance of the regulations, while suggesting a need to monitor their implementation, to ensure that enrollees are given sufficient information to facilitate informed decision-making. Recent political events, however, have put the future of the regulations in question.

LOOKING AHEAD

Since managed care has ceased to be an experiment and has become the way Medicaid-funded care is paid for and delivered, the Balanced Budget Act and its accompanying regulations have established a set of basic, uniform national standards for Medicaid managed care. These standards are critical to the provision of responsible family planning care for three major and interconnected reasons. First, they are clear and forthright in emphasizing that the states, while contracting with managed care plans, retain the obligation to ensure that enrollees have access to all Medicaid-covered services. This principle has especially significant implications for services that some providers, and even some entire managed care plans, may refuse to offer because of religious beliefs or moral convictions. Second, the standards retain the right of enrollees to obtain family planning services from providers of their choice; they thus afford access when services are not available within a particular managed care plan. Finally, they recognize that unless enrollees are given complete and understandable information, their ability to exercise their rights and obtain the care they need and to which they are entitled will be greatly diminished.

The Balanced Budget Act has been correctly characterized as "one of the most important pieces of Medicare and Medicaid legislation since both programs were originally created in 1965."[73] But the law must be fully and responsibly implemented to ensure that Medicaid will continue to play the critically important role it has in supporting the provision of family planning services and supplies to poor women in the United States. Congress and the Clinton administration have played their parts. Now the responsibility lies with the Bush administration and the states.

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Box: When a Plan Opts Out

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