

# Medicaid and Managed Care: Meeting the Reproductive Health Needs of Low-Income Women

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*State Medicaid programs have increasingly turned to managed care with hopes of controlling spending while improving access to care. The move to managed care has significant implications for the provision of reproductive health services—family planning, abortion, sterilization, sexually transmitted diseases, and maternity care. However, the delivery of reproductive health services in a Medicaid managed care environment is wrought with many difficulties. The complexity inherent in Medicaid policy, the changing world of managed care, and the health and social needs of the Medicaid population are compounded by the sensitive nature of reproductive health needs.*

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Key words: *managed care, Medicaid, women's health services*

**M**IRRORING TRENDS in the private sector, state Medicaid programs have increasingly turned to managed care with hopes of controlling spending while improving access to care. Today, nearly half, or more than 15 million Medicaid beneficiaries are enrolled in managed care.<sup>1</sup> The move to managed care has particularly significant implications for the provision of reproductive health services such as family planning, abortion, sterilization, treatment of sexually transmitted diseases (STD), and maternity care.

Providing reproductive care through Medicaid managed care arrangements poses challenges for beneficiaries, health care providers, health plans, and state agencies alike. Navigating the complexities inherent in the Medicaid program is no small feat. These include confusing and arcane eligibility policies, administrative hurdles, limited provider availability, and notoriously slow and low payment rates. In recent years, a new layer of intricacy has been placed on this flawed but vitally important safety net

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The views expressed are those of the authors and do not necessarily represent those of the Henry J. Kaiser Family Foundation or the Kaiser Commission on Medicaid and the Uninsured. The authors would like to thank Patricia Keenan, Sara Rosenbaum, two anonymous reviewers for their comments on earlier drafts, and Dawn Nelson for her able editorial assistance.

program—managed care. Medicaid beneficiaries are now commonly faced with learning how to use a new system of care and developing relationships with a new set of providers.

These changes do not affect beneficiaries alone. Providers, particularly those who have traditionally cared for the poor, are faced with a new range of activities. In part, these include competing for patients, negotiating contracts, and establishing or joining networks. State agencies are now charged with a new set of responsibilities, including assuring that plan networks are adequate and include the providers that best meet the complex health and social needs of Medicaid beneficiaries. State agencies also must take extra precautions to ensure that beneficiaries are protected from the many incentives in managed care to provide less care. Compounding these difficulties is the sensitive nature of reproductive health care, which adds the challenges of confronting societal preconceptions and taboos in the health care environment.

This article provides a brief overview of the reproductive health care needs of low-income women, discusses Medicaid's role in financing reproductive health services, and reviews trends in managed care for the Medicaid population. It also raises considerations for program administrators and policymakers that are integral to assuring that managed care best serves the reproductive health care needs of low-income women.

### **Reproductive Health Care Needs of Low-Income Women**

Specifying the reproductive health care needs of low-income women is not simple. There is no standard definition of reproductive health care, and information about the specific health concerns of different income groups is not readily available. For the purposes of this discussion, reproductive health services are defined to include: routine gynecologic examinations; contraceptive counseling, services, and supplies; STD and human immunodeficiency virus (HIV) counseling, diagnosis, and treatment; screening for cancers of the reproductive system, including cervical and breast cancers; infertility services; abortion counseling and services; and pregnancy-related care.<sup>2</sup> To varying degrees, state Medicaid programs cover most of these services.

To qualify for Medicaid, an individual must meet Medicaid's income criteria and be pregnant and low income, eligible for welfare assistance\* (usually women with young children in their peak childbearing years), disabled and eligible for Supplemental Security Income (SSI), or over age 65. Because of this eligibility policy, the adult Medicaid population is overwhelmingly comprised of low-income women. Nearly three-quarters (71%) of the non-older adults that Medicaid covers are women, and of these women, 81 percent are between the ages of 18 and 44.<sup>3</sup>

While women enrolled in Medicaid have reproductive health needs and problems similar to those of their privately insured counterparts, many of those needs experienced by low-income women are compounded by poverty, low-educational attainment, and lack of access to timely and appropriate health care. As a result of these and other factors, low-income women experience a disproportionately greater incidence of unintended pregnancy, STDs, poor birth outcomes, and shorter survival times for cervical and breast cancer.

Unplanned pregnancy—while a problem among all groups of sexually active women of reproductive age—is especially prevalent among low-income women. Among poor women surveyed in the 1995 National Survey of Family Growth, 61 percent classified their pregnancies as unintended, compared with 41 percent of women whose incomes exceeded 200 percent of the poverty level.<sup>4</sup> Contraceptive use also varies with income. Low-income women are less likely than women with higher incomes to use contraception and more likely to have more difficulty using contraceptives regularly and correctly.<sup>5</sup> As a result, low-income women are more likely to get pregnant even when they report using contraception.<sup>6</sup>

While no data are available on the specific relationship between income and the incidence of STDs, information is available on STD rates by race and ethnicity. In the United States, race and ethnicity have been found to be risk markers that correlate with other basic determinants of health status such as

\*The new welfare law eliminated the automatic link between cash assistance under Aid to Families with Dependent Children (AFDC) with a new block grant to states called Temporary Assistance for Needy Families (TANF). The new law requires states to use the AFDC eligibility criteria of July 1996 (before the law changed) to determine Medicaid eligibility for families with children.

poverty and access to health care. Women from some minority racial and ethnic groups have higher rates of STD and HIV infection than nonminority women.<sup>7</sup>

Similarly, although all sexually active women are at risk for cervical cancer, this preventable cancer is more commonly found in poor women.<sup>8</sup> While poor women are less likely to get breast cancer than are women with higher incomes,<sup>9</sup> women who are on Medicaid or are uninsured were found to have more advanced breast cancer at the time of diagnosis and have worse survival rates than privately insured women.<sup>10</sup> Cancer prevention efforts, including Pap smears, breast exams, and mammograms, are encouraged for all women, but those who are poor do not receive these screenings at recommended rates or at rates comparable to their higher income counterparts.<sup>11</sup>

### Medicaid's Role in Reproductive Care

Medicaid, the jointly financed state-federal health care program for the poor, plays a key role in covering reproductive health care for low-income women. To participate in Medicaid, a state must agree to provide beneficiaries with a mandatory set of benefits, which include: inpatient and outpatient hospital care; physician, midwife, and certified nurse practitioner services; laboratory and X-ray services; and family planning services. A state also can provide optional services such as prescription drugs, screening, and preventive care. Medicaid covers a broad range of reproductive care, including family planning services and supplies (reimbursed at a 90% federal match), STD screening and treatment, prenatal care and delivery, and sterilization (only for individuals who are 21 years and over, mentally competent, and voluntarily give informed consent). Infertility treatment is defined as a family planning service under Medicaid, though the extent to which women on Medicaid can use this service is unknown. Federal funds can be used for abortions sought by Medicaid beneficiaries only in cases of life endangerment, rape, or incest. A state can use its own funds to pay for medically necessary abortions, but only 17 states currently do this to varying degrees.<sup>12</sup>

Because of their poor health status and greater health care needs, women on Medicaid seek health care more often each year than their low-income, privately insured and uninsured counterparts.<sup>13</sup> Low-

income women on Medicaid or other public insurance are also more likely than women with private insurance to have made a gynecologic visit in the last year.<sup>6</sup> This can be attributed to the fact that women eligible for Medicaid include those who are pregnant or in their peak reproductive years. Where women get reproductive care also differs by insurance type. Compared with women who have private insurance, women who are covered by Medicaid or are uninsured are also more likely than those with private insurance to have obtained gynecologic care in a clinic-based setting than from a private doctor's office or health maintenance organization (HMO).<sup>6</sup>

Several indicators—such as the use of family planning services, pregnancy-related care, and preventive screenings—shed light on Medicaid's important role covering reproductive health care. Medicaid is the largest single source of public funding for family planning services, financing 46 percent of all public spending on contraceptive services.<sup>14</sup> For example, in 1995, Medicaid provided family planning services to 2.5 million Medicaid beneficiaries on a fee-for-service basis at a cost of \$500 million (representing less than 1% of total Medicaid spending).<sup>15</sup> Because most services under full- and partial-risk managed care arrangements are paid for on a capitated basis, it is unknown on a national level what share of Medicaid spending went to family planning services for women enrolled in managed care.

One of Medicaid's most significant roles is financing pregnancy-related care. As a result of federal and state expansions of eligibility for pregnant women in the late 1980s and early 1990s, Medicaid has become a dominant payer for births. Medicaid pays for approximately 40 percent of all births in the United States, and more than half of all births in Georgia, Louisiana, Mississippi, New Mexico, and West Virginia.<sup>17</sup> Today, states are required to extend eligibility to all pregnant women with incomes below 133 percent of the poverty level and can opt to expand coverage to women with incomes up to 185 percent of poverty. Some states have used a variety of mechanisms to broaden eligibility beyond the federal ceiling. Section 1115 Research and Demonstration Waivers allow states to expand eligibility beyond federal requirements, while the Section 1902(r)(2) option allows states to use the more liberal income and assets test to determine Medicaid eligibility for children and pregnant women. Thirty-four states have ex-

tended eligibility to pregnant women who are beyond the federal floor of 133 percent of poverty.

Medicaid also plays a critical role for low-income women by covering preventive screening for cervical and breast cancer. Women with Medicaid coverage or private coverage are more likely than uninsured women to receive these services. In a survey of low-income people in five states, about 60 percent of women with Medicaid or private coverage had a Pap smear in the past year, compared with about 40 percent of uninsured women. Similarly, while about half of low-income women between the ages of 50 and 64 with Medicaid or private coverage had a mammogram in the past year, only one quarter of uninsured women reported having had one.<sup>17</sup>

As discussed previously, federal funding of most Medicaid abortions is prohibited by law; two-thirds of states do not provide any Medicaid funding for abortions. Because most poor women must pay for abortions out of their own pockets, an estimated one in five Medicaid-eligible women who had second-trimester abortions would have had first-trimester abortions if the lack of public funds had not delayed raising sufficient money to pay for the procedure.<sup>18</sup> As a result of this policy and other factors, low-income women with unplanned pregnancies are less likely to have an abortion than their higher-income counterparts.<sup>19</sup> If they do have an abortion, they are more likely than their higher-income counterparts to have a higher risk, more expensive second-trimester abortion.

Despite Medicaid's important role, the low-income women it covers often experience difficulty gaining access to the reproductive health care services they need. From preconception counseling to postpartum care, cancer screening, and treatment, low-income women—including those with Medicaid coverage—do not receive recommended levels of services. The key question is whether the shift to Medicaid managed care improves or exacerbates this situation.

### **Medicaid Managed Care and Reproductive Health**

Medicaid's use of managed care has grown explosively in the past decade. In 1987, an estimated 1.8 million Medicaid beneficiaries were enrolled in managed care arrangements. By 1997, enrollment had reached an estimated 15.3 million, about 48 percent of the Medicaid population. Although there are

no precise estimates of the composition of the Medicaid managed care population, almost 90 percent of \$9.9 billion in federal and state Medicaid payments to managed care organizations (MCOs) is estimated to be on behalf of children and their families (usually their mothers).<sup>20</sup>

Under Medicaid, managed care includes a wide array of arrangements designed to control costs and improve access. These arrangements usually follow one of three general models: primary care case management (PCCM); full-risk plans, such as HMOs; and limited-risk, prepaid health plans (PHPs). About one-third of Medicaid managed care enrollees are enrolled in PCCM arrangements, which identify a specific provider as the patient's gatekeeper and reimburse that provider on a fee-for-service basis.

Although states have always been able to allow beneficiaries to enroll in managed care voluntarily, they could not require beneficiaries to enroll in managed care plans until recently without a waiver from the Health Care Financing Administration (HCFA). Today, most states that mandate managed care enrollment are using either Section 1915(b) (freedom of choice) or Section 1115 (research and demonstration) waivers to waive the freedom of choice of provider provisions of the Social Security Act. As of March 1997, 40 states and the District of Columbia were operating nearly 100 1915(b) managed care waiver programs; and 18 states had received HCFA approval for Section 1115 waivers. As a result of the enactment of the Balanced Budget Act (BBA) of 1997, states can now require managed care enrollment for all Medicaid beneficiaries—except children with special needs, dually eligible Medicaid/Medicare beneficiaries, and American Indians—under the new Section 1932 of the Social Security Act. This means that states no longer need to obtain waivers to mandate enrollment in managed care for most Medicaid beneficiaries.

In the mid-1980s, the freedom of choice legislation was enacted to protect access to timely and confidential family planning services for Medicaid beneficiaries in managed care, and to protect family planning providers without managed care contracts who otherwise would have lost a large base of patients.<sup>21</sup> These provisions are referred to as the family planning "freedom of choice" provisions. Thus, even if a beneficiary is enrolled in managed care, she can seek family planning services out-of-plan.

The type of waiver under which a state operates its mandatory managed care plan has implications for access to reproductive health care, particularly for family planning services. With Section 1915(b) waivers, states must allow all women in managed care plans to use their family planning provider of choice, even if family planning services are included in the plan's capitated rate. In contrast, states with Section 1115 waivers may request federal permission to require women to seek all family planning services from their plans, although few states have actually applied to waive these freedom of choice provisions. Because many states are opting to continue to operate their waiver program after passage of the BBA, the distinctions between the types of waiver programs are still relevant today for women in Medicaid managed care. The BBA is silent on family planning provider freedom of choice, which effectively maintains the ability of managed care enrollees to go outside their plans to obtain family planning services from the providers of their choice.

If a state supports Medicaid managed care beneficiaries' freedom of choice of family planning provider, it is incumbent on both plans and state Medicaid programs to provide information to members about their right to obtain family planning services directly from providers of their choosing. Most state agencies classify the following as family planning: contraceptive counseling, patient education, related examinations and treatment; laboratory tests for STDs, HIV, and pregnancy; Pap smears; and contraceptive devices. However, a number of reproductive services—including hysterectomies, breast exams, maternity care, abortion services, and treatment for STDs—are generally excluded from most state definitions of family planning services for the purposes of the freedom of choice exemption.<sup>22</sup>

Some states have also used Section 1115 waiver authority to expand Medicaid coverage for a limited range of family planning services for women who otherwise would be ineligible for Medicaid assistance. Eight states have expanded coverage to an estimated 35,000 women who would not qualify for assistance because they are either no longer pregnant and do not meet Aid to Families with Dependent Children (AFDC) eligibility criteria, or because they lost Medicaid coverage for other reasons.<sup>23</sup> The goal of these limited-scope Section 1115 waiver programs is to decrease unwanted and mistimed pregnancies

by increasing access to family planning services. These waivers must demonstrate federal budget neutrality, which is evaluated over the lifetime of the waiver and is assessed by comparing estimated savings from averted births and costs during the first year of life to the costs of expanded family planning services. Of the states that have been granted waivers, two require that women receiving family planning benefits enroll in an MCO. However, most states allow full freedom of choice of provider and pay for provider services on a fee-for-service basis.

One of the other key functions of Medicaid is financing prenatal care. Many states have used 1915(b) waivers to enroll pregnant women in managed care with the goal of increasing coordination and integration of care, providing unique community education and other specialized, nonmedical social and preventive services, and controlling spending.<sup>24</sup> Despite managed care's potential for innovation, most prior evaluations have not found that managed care improves access to prenatal care, the adequacy of care, or birth outcomes for the women enrolled in Medicaid managed care.<sup>25–27</sup>

### **Specific Issues in Delivering Reproductive Health Services**

Much has been written about the challenges and opportunities managed care poses as an approach for the delivery of care to the low-income population. In general, the evidence is mixed because managed care does not appear to significantly improve access over fee-for-service arrangements, nor does it consistently appear to restrict access or worsen health outcomes.<sup>28</sup> Studies suggest that access and quality vary tremendously with type of plan and provider. Regardless of whether one views the growth of managed care as a positive or negative trend, managed care for the Medicaid population is rapidly becoming the dominant approach for the delivery of care to low-income women. Health care providers, administrators, and others concerned about access to reproductive health care services for women must consider other issues as they work to assure that low-income women have access to care.

#### **Access and availability of care**

All women, regardless of socioeconomic status or Medicaid eligibility, benefit from having the broad-

est possible range of reproductive health services. The Medicaid managed care contracting process can be used to ensure that coverage is comprehensive and that beneficiaries are able to seek reproductive health care from sources with which they are comfortable. Medicaid beneficiaries enrolled in managed care plans remain entitled to the full spectrum of Medicaid benefits even if the services are not included in the state's contract with the MCO. However, if specific reproductive health services are not included explicitly in a managed care contract—or are not discussed with the beneficiary by her primary care provider—the beneficiary may not know she is entitled to them.

States have flexibility in determining which benefits and service plans are included in their contracts. They also have the authority to identify which providers must be included as members of managed care networks, though most states give plans considerable discretion over the composition of their networks. In a landmark study of Medicaid managed care contracts, Rosenbaum and colleagues found broad variation among states in the specificity of reproductive health services that were covered.<sup>29</sup> Their study found that while a majority of states specified maternity care, enhanced prenatal services, and family planning services, only a handful specifically mentioned in their contracts coverage of intrauterine devices (IUDs), Depo-Provera, and Norplant. Similarly, only a fraction of states specifically identified infertility and other gynecological services in their contracts. Unless these benefits are specified in the contract, the plan or the network is not required to provide them, even though the beneficiary is still entitled to receive them from Medicaid-qualified providers outside of the plan.

Since *Roe v. Wade* in 1973, there have been legislative efforts to permit individuals and some medical facilities to refuse to provide services to which they have moral, ethical, or religious objections, such as abortion. "Conscience clauses" have reemerged with the growth of managed care, and their impact has expanded with the rapid rate of new affiliations between payers and providers of care, both religious and secular. Given that Medicaid recipients are already restricted in where they can seek care because of their insurance status, further limitations on the services their managed care plans provide can create serious barriers to care. The BBA allows Medicaid

managed care plans, not just individuals, to refuse to "provide, reimburse for, or provide coverage of, any counseling or referral service to which it has a moral or religious objection." Plans that implement this option are required to alert beneficiaries of this denial. Ideally, these beneficiaries will continue to have alternative sources—such as freestanding family planning clinics—from which to seek care within the Medicaid system. But choices may be particularly limited in rural areas where there may be only one provider of reproductive health services. Because women still have legal entitlement to these services under Medicaid, it will be critical that states ensure that women are informed of their rights to family planning services and receive full access to these services regardless of what plan they are enrolled in.

The advent of Medicaid managed care has had serious implications for organizations that provide reproductive health services and are not included in Medicaid managed care networks. Because of the lack of office-based obstetrician-gynecologists participating in Medicaid, low-income women have grown to rely heavily on family planning clinics or STD clinics for contraceptive services and STD testing and treatment.<sup>30</sup> These providers, who have been instrumental for decades in providing care to people for whom other caregivers are inaccessible, depend on Medicaid for their financial viability. However, many plans are reluctant to work with these providers. When the Kaiser Family Foundation surveyed a nationally representative sample of members of the American Association of Health Plans (then Group Health Association of America) in 1994, just 18 percent of managed care plans were interested in contracting out for reproductive health services, and only 9 percent had current contracts to do so. The majority of plans in the survey stated potential interest in contracting out for family planning and abortion services, with only a minority interested in contracting out services related to STDs, prenatal care, breast screening, pelvic exams, and Pap smears.<sup>31</sup>

Many of these traditional family providers have pushed for various reproductive health services to be "carved out" of Medicaid managed care so that beneficiaries can seek these services from any qualified Medicaid provider, not just those "within-plan." In a survey of women's health centers, Weisman and colleagues found that only 39 percent of reproductive care providers had managed care contracts.<sup>32</sup> The free-

dom of choice provisions have made it possible for some traditional providers to continue to operate in a time when funds for family planning services are diminishing. However, these providers continue to find themselves financially pressed and are concerned about their continued ability to provide care to the millions of low-income women who lack coverage.<sup>32</sup>

### **Coordinating and integrating care**

One of the hallmarks of managed care is care coordination. To the extent that a patient's reproductive health is linked to other facets of her health, and that the various aspects of her reproductive health are linked to each other, coordination of care is advantageous. A fractured health care system in which Medicaid managed care enrollees seek their reproductive health care outside of the plan may be at odds with this principle, unless the MCO and out-of-plan providers establish protocols to share information about patient care.

However, the sensitivity of some of the services involved—sterilization, abortion, contraception, screening and diagnosis for STDs, and infertility diagnosis and treatment—may lead to patients' desire for confidentiality from family members, employers, and even from their ongoing health care providers about the services they receive. While some managed care plans permit obstetrician-gynecologists to be primary care providers, or allow women to self refer to them, many plans allow generalist primary care providers to manage their patients' reproductive health care.

Even with their obstetrician-gynecologists, who are relatively accustomed to discussing sensitive reproductive issues, many women do not discuss issues that directly affect their reproductive health. A recent survey found that 30 percent of sexually active women who did not wish to become pregnant did not discuss birth control with their physicians at the time of their gynecological visit; neither the physician nor the patient raised the topic.<sup>33</sup> At women's first visits, obstetrician-gynecologists asked about birth control only 33 percent of the time, HIV and acquired immune deficiency syndrome (AIDS) 19 percent of the time, and STDs other than HIV/AIDS only 12 percent of the time.<sup>34</sup> It is likely that generalist primary care physicians are less willing than obstetrician-gynecologists to initiate conversation with their patients about these topics.

Finally, concern about confidentiality may compromise access to reproductive health services. For example, access to health care for teenagers is most often based on the insurance status of a parent. Needing the family insurance card may effectively reduce access to reproductive health services for a teen reluctant to share her health concerns. If a plan sends home an explanation of the benefits it provided to a teen, it may reveal to parents those services that the teen wished to keep confidential. Adults can also be faced with these dilemmas if their insurance coverage is through their spouses or domestic partners. In general, patients' desires for confidentiality regarding reproductive health care also may be at odds with coordinating care.

### **Monitoring care and plan accountability**

As managed care becomes the dominant delivery system for providing care to low-income women on Medicaid, there is increasing pressure on states to assure that the care provided by MCOs meet quality standards. There are, however, a number of difficulties in assessing the quality of reproductive health care for Medicaid managed care beneficiaries that are related to measurement tools, data collection, and states' ability to use data to monitor care and gauge quality.

There are currently a number of initiatives underway to provide measures of the quality of care under managed care. One of the most prominent initiatives is the Health Plan Employer Data and Information Set (HEDIS). The most recent iteration, HEDIS 3.0, was developed, in part, to capture many of the dimensions of care that are relevant to the Medicaid population. The current HEDIS reporting set contains a number of reproductive health indicators. These include measures for breast and cervical cancer screening, a description of the plan's network of family planning providers (for use with Medicaid reporting only), and some indicators of the accessibility and availability of prenatal care and delivery services. However, the number of measures is very limited. Several measures are being evaluated for inclusion in a future HEDIS that would broaden the scope of measurement of reproductive health services. These would include measures for chlamydia screening, follow-up treatment after abnormal Pap smears and mammograms, stage of breast cancer detection, HIV patient management, and counseling

about hormone replacement therapy for women.<sup>35</sup> However, even this expanded testing set falls short of a comprehensive assessment of the quality of reproductive health care in a managed care plan. For example, counseling may be the most important element in preventing unplanned pregnancy, but it is difficult to demonstrate that counseling contributes to the prevention of unplanned pregnancy and to measure the quality of that counseling.<sup>36</sup> Measurement of the quality of reproductive health services will be an important area to develop.

Even if the science of measurement were adequate to assess the quality of reproductive health care, a number of logistical hurdles exist that are important to consider. Major challenges to assessing the quality of care lie in the ability of Medicaid MCOs to collect quality of care measures accurately as well as in the capacity of state agencies to use the data in a meaningful way. Not only has the growth of managed care changed how patients, providers, and plans interact with the health system, it has also created new responsibilities for state agencies. They must invest in training and the acquisition of new information systems to monitor care. One of the important lessons from states that have shifted to managed care is that they must have the infrastructure—including the technology and staff—to oversee the care that MCOs provide to Medicaid beneficiaries.<sup>37</sup> This infrastructure requires a critical investment of resources, which is increasingly difficult for state governments in the face of pressure to reduce staffing levels and administrative costs.

Finally, despite significant managed care enrollment in the Medicaid population, a disproportionate share of Medicaid beneficiaries continues to use traditional family planning providers for reproductive health care. Current Medicaid data systems cannot easily track these women's care or determine whether they obtained care that met existing standards. Concerns about confidentiality, problems with obtaining data on out-of-plan use and care coordination, and limitations on data collection systems make it difficult to collect basic data on the use of services.



Meeting the reproductive health care needs of low-income women in Medicaid managed care presents critical challenges at many levels. Populations new

to managed care must learn to choose plans, select providers, negotiate for reproductive health services through their gatekeeper primary care providers (who may or may not be their obstetrician-gynecologists), and seek care only from health professionals affiliated with their plans, unless they are aware of out-of-plan options. Plans and health care providers must also recognize beneficiaries' need for supplemental services, such as language translation, child care, transportation assistance, and other social services that are beyond the realm of what has been traditionally viewed as medical care. Because of the vulnerability of the Medicaid population, Medicaid sometimes makes demands on MCOs that exceed those of the private sector. It is now incumbent on states to take on responsibilities beyond their historical roles as payers of care. They must learn to be prudent purchasers of care, provide more oversight and monitoring of care, and develop and establish quality standards. This is especially challenging when state administrative budgets and staffs are shrinking.

Finally, as one strives to design a system to meet the reproductive health needs of women in Medicaid managed care, it is important to be cognizant of the considerable discontinuity in Medicaid coverage, because women on Medicaid today are often the very same women who are uninsured next month. Some 28 percent of women on Medicaid have been covered for less than two years, and two-thirds of women who leave the Medicaid program become uninsured.<sup>38</sup> These women have the same reproductive needs whether they have Medicaid coverage or not. This presents difficulties for MCOs because women are often not enrolled for a continuous period of time—perhaps decreasing incentives to provide preventive services that reap benefits to MCOs only in the long term. Discontinuous Medicaid coverage is also problematic for the traditional providers of reproductive health services. The growth of managed care threatens the very survival of the freestanding traditional providers upon whom women will still depend when their coverage runs out. In efforts to assure that Medicaid managed care best meets the needs of low-income women, it will be increasingly important to consider the needs of uninsured women as well. Regardless of insurance coverage or care arrangement, low-income women will continue to need access to a broad range of quality reproductive care services at an affordable price.

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