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Committee on Health Care for Underserved Women

This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Health Care for Underserved Women in collaboration with Sarah Horvath, MD, MSHP.

Protecting and Expanding Medicaid to Improve Women's Health

ABSTRACT: Medicaid, the state–federal health insurance program for individuals with low incomes, serves as a safety net for women throughout the life span. Historically, expansions of Medicaid have been associated with improved access to health care, less delay in obtaining health care, better self-reported health, and reductions in mortality. Compared with nonexpansion states, states that have participated in the Affordable Care Act's Medicaid expansion have experienced improvements in maternal and infant mortality and decreases in uninsured rates and have decreased racial inequities for these measures. In addition to supporting policies that expand access to Medicaid, the American College of Obstetricians and Gynecologists strongly supports education for its members, other obstetrician–gynecologists, and other health care practitioners regarding the complex system for regulation of Medicaid and encourages advocacy for policies that increase access to care for all women. This Committee Opinion has been revised to emphasize the importance of Medicaid to improving women's health, the history and growth of Medicaid, including the ACA's Medicaid expansion, and the mechanisms by which changes to the Medicaid program can occur, and it includes relevant examples for each.

Recommendations and Conclusions

The American College of Obstetricians and Gynecologists makes the following recommendations and conclusions:

- ACOG supports Medicaid policies and regulations that increase access to health care.
- ACOG supports patients' ability to obtain health care from the qualified provider of their own choosing and opposes policies that exclude any willing provider from the Medicaid program.
- To protect access to care for all Medicaid beneficiaries, ACOG supports timely payment at sustainable rates.
- ACOG strongly supports extending pregnancy-related Medicaid coverage beyond the current statutory limit of 60 days to at least 1 year postpartum.
- ACOG opposes policies that decrease access to women's health services in Medicaid.
- ACOG opposes alternative Medicaid financing structures that limit state dollars, decrease Federal funding, and, in turn, impose limits on covered services, reimbursement rates, and/or the number of individuals covered.

Background

Numerous inequities exist in gynecologic and obstetric health outcomes in the United States. Although there are many contributing factors, access to health insurance, including Medicaid, is among the most significant. Medicaid is a public insurance program overseen by the federal government and administered by the states. There are various mechanisms for altering the structure of Medicaid at both the state and federal levels. Medicaid expansion was introduced as part of the Affordable Care Act (ACA). Implementation of the Medicaid expansion began in 2014 and continues to evolve.

Many women in the United States remain uninsured and face avoidable adverse gynecologic and obstetric health outcomes. The American College of Obstetricians

and Gynecologists calls for quality health care appropriate to every woman's needs throughout her life, including care for substance use disorder, infertility, abortion, and cancer (1). Public policies that decrease Medicaid coverage and services disproportionately hurt women (2, 3). The American College of Obstetricians and Gynecologists recognizes the importance of protecting and expanding Medicaid services, reimbursement, and eligibility to improve access to necessary health care and promote health equity. The American College of Obstetricians and Gynecologists supports Medicaid policies and regulations that increase access to health care.

Medicaid, the state–federal health insurance program for individuals with low incomes, serves as a safety net for women throughout the life span. It is the largest payer of pregnancy services, financing between 40% and 50% of all births in the United States, and family planning services, accounting for 75% of all public family planning expenditures (4, 5). In addition to providing critical care to individuals with lower incomes, Medicaid has played a crucial role in advancing women's economic security by decreasing debt and bankruptcy due to medical expenditures (2).

Women with Medicaid coverage use primary care and preventive services at rates that approach those of privately insured women and are less likely to forego care due to cost than their uninsured counterparts (6). In contrast, uninsured women receive less preventive care and treatment for medical conditions, are more likely to be diagnosed at advanced stages of illness, and have higher mortality rates from certain diseases, including breast cancer (6, 7). Additionally, uninsured women receive fewer prenatal care visits and suffer increased rates of adverse maternal and fetal outcomes, which emphasizes the importance of access to health insurance coverage, including Medicaid, for individuals and families (6).

State and Federal Requirements

Medicaid is a public insurance program overseen by the federal government and administered by the states. The federal government contributes a portion of program funding based on each state's per capita income. In return, states are required to meet minimum requirements set by the federal government for covered services, eligible groups of people, and other patient protections. States pay a defined share of the cost for required services and may opt to include additional covered services or special populations that are not required by the federal government, such as infertility care, fertility preservation, or vasectomy, or those that federal funding has historically been barred from covering, such as abortion care.

Medicaid eligibility and coverage vary substantially between states. For example, all pregnant women and children below 138% of the federal poverty level (FPL) must be included in a state's Medicaid program for that state to receive federal funds. However, a state may choose to include pregnant women above that income threshold, nonpregnant women, and/or institute "presumptive eligibility," which allows temporary enrollment of pregnant women into Medicaid during application processing. Medicaid coverage is not portable across state lines except in limited circumstances. The American College of Obstetricians and Gynecologists recognizes the need for obstetrician–gynecologists to be educated about and understand the covered services and eligibility requirements of their own state Medicaid program in order to adequately care for patients. This knowledge can aid with filling identified gaps to expand services and coverage to more individuals.

States can alter their Medicaid programs through a number of mechanisms including State Plan Amendments and Section 1115 waivers. State Plan Amendments are submitted by states to the federal Centers for Medicare and Medicaid Services (CMS) when states want to change, update, or make corrections to their Medicaid policies or operational approach. These changes, if approved, become permanent parts of a state's Medicaid program.

Section 1115 waivers are designed to "focus on evidence-based interventions that drive better health outcomes and quality of life improvements" (8). These waivers were created so that states could improve access to Medicaid services by testing novel strategies, for example, by expanding coverage for individuals living with HIV/AIDS. Importantly, these strategies should not limit access to care by imposing onerous administrative burdens on clinicians or restrictive and punitive policies on patients in favor of purported short-term fiscal savings. Programs that increase patient barriers to care without proven health benefits, such as mandatory work requirements, inappropriately deny care to eligible individuals (9). The American College of Obstetricians and Gynecologists opposes policies that decrease access to women's health services in Medicaid.

Section 1115 waivers are subject to both state- and federal-level public comment periods before approval by CMS. This opportunity for public comment can be used to proactively advocate for expanded coverage. For example, in 2020, several states submitted Section 1115 waivers to CMS seeking to extend the period of postpartum eligibility under pregnancy-related Medicaid. The American College of Obstetricians and Gynecologists strongly supports extending pregnancy-related Medicaid coverage beyond the current statutory limit of 60 days to at least 1 year postpartum. A growing body of literature supports extending postpartum coverage through the Medicaid program (10–12). The Centers for Disease Control and Prevention (CDC), Maternal Mortality Review Committees, and ACOG all recognize the importance of continued access to health care beyond the traditional postpartum visit (13, 14). In the CDC's Pregnancy Mortality Surveillance System data from 2011 to 2015, 11.7% of pregnancy-related deaths occurred

between 6 weeks and 1 year postpartum (15). The two leading causes of death were cardiomyopathy and mental health conditions, both of which can be ameliorated by access to continuous, comprehensive, and affordable health coverage through Medicaid. In addition, an increasing number of pregnancy-associated deaths, including those linked to overdose and suicide, occur well beyond Medicaid's arbitrary 60-day cutoff (16, 17). Obstetrician–gynecologists used the public comment opportunity to voice support for these proposals.

Medicaid Program Financing Structure

States have latitude in determining the amount, duration, and scope of benefits, eligibility requirements, and reimbursement rates for their respective Medicaid programs, with financial support provided through the federal medical assistance percentage (FMAP), often referred to as the "federal match." Under the current Medicaid financing structure, the federal government provides FMAP funds for all covered services for all eligible beneficiaries within a state. The FMAP for most eligibility categories is determined by a formula that factors in the per capita income of a state. This financing structure allows states to tailor their programs to the individual needs of their Medicaid enrollees.

States that have expanded Medicaid under the ACA receive a higher FMAP for services provided to this population. There are large disparities in income eligibility between expansion states versus nonexpansion states. The median threshold for parents to qualify in nonexpansion states is 41% of the FPL ($8,905 in 2020 for a family of three), while adults without children seldom qualify. By contrast, otherwise eligible adults with incomes up to 138% FPL ($29,974 in 2020 for a family of three) can qualify for Medicaid coverage in expansion states (18).

Puerto Rico, as a U.S. territory, receives a block grant from the federal government to administer its Medicaid program instead of receiving FMAP. The limits of the block grant financing structure were quickly revealed during the Zika virus outbreak. Low reimbursement rates had decreased the availability of contraceptive services, leaving women with limited options to avoid pregnancy while at high risk for exposure to Zika (19). Capacity for health care delivery was further weakened by multiple hurricanes on the island because, in a block grant system, any unscheduled expenditures must be offset by limiting services, payment, or eligibility elsewhere. Without the flexibility afforded by FMAP, Puerto Rico struggled to provide comprehensive care to its Medicaid beneficiaries during this time of high need (20).

Attempts by policy makers to alter the Medicaid financing structure, such as through block grants or caps on spending per beneficiary (known as per capita caps), would severely constrain the amount of federal financing available to states to administer their programs. Under these alternative financing structures, states would be reliant on fewer financial resources to cover individuals with low incomes. These limits would negatively affect patients by forcing states to make cuts on which services are covered, the rates at which they are covered, and the number of people who are eligible for coverage.

Outbreaks, natural disasters, and other health crises, such as increasing rates of substance use disorder or downturns in the economy, may create sudden, unexpected increases in necessary health care spending and may disproportionately affect certain regions or groups of people. The American College of Obstetricians and Gynecologists opposes alternative Medicaid financing structures that limit state dollars, decrease Federal funding, and, in turn, impose limits on covered services, reimbursement rates, and/or the number of individuals covered.

Medicaid Expansion and the Affordable Care Act's Impact on the Program

Historically, expansions of Medicaid have been associated with improved access to health care, less delay in obtaining health care, better self-reported health, and reductions in mortality (21). In an attempt to build on this success, the Affordable Care Act (ACA) mandated that all states and the District of Columbia expand their Medicaid programs to cover all nondisabled adults under 65 years of age who were U.S. citizens or lawfully permanent residents in the country for more than 5 years with incomes up to 138% FPL. However, the U.S. Supreme Court decision in *National Federation of Independent Business (NFIB) v. Sebelius* made state expansion of Medicaid eligibility optional, creating a patchwork of Medicaid income eligibility thresholds across the country (22) (See an interactive map with current Medicaid expansion status by state at https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/). Compared with nonexpansion states, states that have participated in the Affordable Care Act's Medicaid expansion have experienced improvements in maternal and infant mortality and decreases in uninsured rates and have decreased racial inequities for these measures (23, 24).

In addition to mandating eligibility levels, the ACA required coverage of preventive health services as outlined by the Institute of Medicine, including all female Food and Drug Administration (FDA)-approved methods of contraception (25). This provision, however, applies only to patients eligible through the ACA's Medicaid expansion. Although states may choose to extend this coverage to all Medicaid beneficiaries, they are not required to do so by federal law. Further, ongoing regulatory efforts could weaken these benefits by allowing certain entities to seek religious or moral exemptions to providing coverage for contraceptive care (26, 27). The American College of Obstetricians and Gynecologists supports efforts to codify these federal protections in state law.

The ACA's Medicaid expansion is a necessary but insufficient attempt at universal health insurance coverage. In 2018, women of reproductive age had a higher uninsured rate (11.9%) than adults overall (11.3%) (28, 29). Indeed, even with complete uptake of the Medicaid expansion outlined in the ACA, 8.0% of women would remain uninsured (30). Those remaining uninsured are more likely to be nonelderly adults, people of color, families with low incomes, and families with at least one worker (31). Twenty-three percent of uninsured people are noncitizens, some of whom may qualify for Medicaid depending on their state of residence (31). Some states cover pregnant immigrants with state funds regardless of immigration status, providing a model for potential advocacy. Additional policies to ensure coverage of all women throughout the lifespan should be undertaken, including policies to further expand Medicaid coverage to more people.

Ensuring Patient Access to Care

Federal statute notes that "any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required…]," (32). Any attempts by CMS or state and federal policy makers to eliminate beneficiary access to certain women's health care practitioners are inappropriate, ill-advised, and dangerous for patient health. These restrictions are often based on political ideology and have no basis in licensure, certification, or patient safety. Moreover, these restrictions interfere with patient autonomy and the patient–physician relationship, and they exacerbate the primary care clinician shortage in the United States by removing some obstetrician–gynecologists from the Medicaid provider pool.

Private practices and other community-based practices, such as Federally Qualified Health Centers (FQHCs), would not be able to adequately absorb the number of publicly-insured patients forced to seek new providers in the wake of any exclusion of qualified providers, such as Planned Parenthood, from the Medicaid program (33) (See "Can Community Health Centers Fill The Health Care Void Left By Defunding Planned Parenthood?" at https://www.healthaffairs.org/do/10.1377/hblog20170127.058486/full/). The American College of Obstetricians and Gynecologists supports patients' ability to obtain health care from the qualified provider of their own choosing and opposes policies that exclude any willing provider from the Medicaid program.

Federal statute requires that state Medicaid programs adequately reimburse health care providers at rates high enough to ensure access to care for beneficiaries (34). Setting appropriate payment rates for services allows obstetrician–gynecologists and other health care practitioners to provide more equitable care to patients. To protect access to care for all Medicaid beneficiaries, ACOG supports timely payment at sustainable rates.

In general, the Medicare program establishes payment rates for medical care. All Medicaid-covered services should be paid at the Medicare rate or above to be commensurate with the time and resources required for quality provision of care. In states that administer Medicaid through Managed Care Organizations (MCOs), payment for contraceptive services can be even more complex. Family planning care can be obtained from any willing provider, regardless of a patient's MCO network, but systems for out-of-network referral and reimbursement vary by state and MCO (35). Formularies that limit contraceptive options may create additional barriers to appropriate care. Reimbursement by MCOs for covered services should occur in a timely manner so that practices can maintain adequate financing to continue to care for Medicaid beneficiaries.

Conclusion

Medicaid is a critical health care program for many women with low incomes across the life span. Medicaid eligibility and services should be protected and expanded to provide greater access to the full range of services to support women's health care needs. There are mechanisms in place to make services more comprehensive and equitable including State Plan Amendments, section 1115 waivers, and state and federal regulations that can be used to efficiently expand Medicaid eligibility and covered services rather than limit care. In addition to supporting policies that expand access to Medicaid, ACOG strongly supports education for its members, other obstetrician–gynecologists, and other health care practitioners regarding the complex system for regulation of Medicaid and encourages advocacy for policies that increase access to care for all women.

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