REPORT OF THE
DEPARTMENT OF MEDICAL
ASSISTANCE SERVICES

STUDY OF MEDICAID RECIPIENTS' DIRECT ACCESS TO OBSTETRIC AND GYNECOLOGICAL SERVICES

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 6

COMMONWEALTH OF VIRGINIA
RICHMOND
1998

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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August 29, 1997

TO: The Honorable George Allen

and

The General Assembly of Virginia

This report contained herein is pursuant to House Joint Resolution 598, passed by the 1997 General Assembly.

This report constitutes the response of the Department of Medical Assistance Services to this bill and offers recommendations regarding Medicaid recipients' direct access to obstetric and gynecological services.

Respectfully submitted,

Joseph M. Teefey, Director
Department of Medical Assistance Services

PREFACE

HJR 598 requests the Department of Medical Assistance Services to study Medicaid recipients' direct access to obstetric and gynecological services. The Department is requested to determine the costs and benefits of allowing female Medicaid recipients direct access to obstetricians and gynecologists, and offer such recommendations as it may deem appropriate.

Input was requested from interested provider groups by sending a draft copy of the report for review and comments. Interested providers contacted were:

Martika Parsons
Medical Society of Virginia

Lynn Poole
Virginia Council of Nurse Practitioners

Judy Castleman
Virginia Chapter of the American College of Nurse Midwives

Melanie Gerhart
Virginia Obstetrical and Gynecological Society

Carmen Stuart, Intern
Virginia Hospital and Health Care Association

James L. Ghaphery, MD
Virginia Academy of Family Physicians

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EXECUTIVE SUMMARY

The Department was requested to study Medicaid recipients' direct access to obstetric and gynecological services. The Department reviewed claims data prior to the 1991 implementation of MEDALLION, the primary care physician managed care program and data prior to the 1995 implementation of managed care under health maintenance organizations. We also reviewed our Medicaid contracted providers to determine if there were providers of obstetric and gynecological services available in each city and county.

The implementation of primary care physician managed care does not appear to have had an impact on the ability of recipients to access a variety of provider types. The Department currently has a broad range of provider types under contract to provide obstetrical and gynecological care.

The Department recommends a change in the MEDALLION regulations to allow Medicaid recipients the same freedom of choice as the standard that has been established for individuals under private insurance and health maintenance organizations. Medicaid recipients could then see a physician for gynecological services without a referral.

OVERVIEW

Historically, recipients of Medicaid were allowed to access care from any Medicaid participating provider as required under Medicaid law. Section 1902(a)(23) of the Social Security Act provides that recipients may obtain services from any qualified Medicaid provider that undertakes to provide the services to them. Section 1915(b) of the Act protects the right of recipients to seek family planning services from the Medicaid provider of their choice, even if their other care was provided under a managed care program that restricted them to certain providers.

In 1992, the Department implemented MEDALLION, a primary care physician (PCP) managed care program. Under MEDALLION, the recipient is required to obtain a referral from their primary care physician to obtain services from other providers, with the exception of family planning services. Federal regulations at 42 CFR 431.51 (b)(2) state that a recipient enrolled in a primary care case-management system, an HMO, or other similar entity will not be restricted in freedom of choice of providers of family planning services.

Additionally, under MEDALLION, Virginia regulations at 12VAC30-120-290 (Providers of services) state that providers who may enroll to provide MEDALLION services include, but are not limited to, physicians of the following primary care specialties: general practice, family practice, internal medicine, and pediatrics. Exceptions may be as follows:

1. Providers specializing in obstetric/gynecologic care may enroll as MEDALLION providers if selected by clients as PCPs but, only if the providers agree to provide or refer clients for primary care.

2. Physicians with subspecialties may enroll as MEDALLION providers if selected by clients as PCPs but only if the providers agree to provide or refer clients for primary care.

3. Other specialty physicians may enroll as PCPs under extraordinary, client-specific circumstances when the Department determines, with the provider's and recipient's concurrence, that the assignment would be in the client's best interests. Such circumstances may include, but are not limited to: the usual-and-customary practice of general medicine by a board-certified specialist; to maintain a pre-existing patient-physician relationship; or to support the special medical needs of the client.

4. The Department shall review applications from physicians and other health care professionals to determine appropriateness of their participating as a MEDALLION PCP.

5. The PCP must have admitting privileges at a local hospital or must make arrangements acceptable to the Department for admissions by a physician who does have admitting privileges.

Under the MEDALLION program at 12VAC30-120-310, obstetrical services are exempted from the supervision and referral requirements. Because the regulations do not specifically exempt them, a referral is required for gynecological services.

In 1995, the Department implemented *Options*, a voluntary HMO managed care program, in areas of the state where HMOs are available. In 1996, Medallion II, which requires that recipients enroll in HMOs, was implemented in the Tidewater area of the state. Under Medallion II regulations at 12VAC30-120-380 (Medallion II Provider Responsibilities (B)), clients may also seek emergency services and family planning services from a provider outside the HMO. The HMOs shall pay for emergency services and family planning services whether they are provided inside or outside the HMO network.

In 1996 the General Assembly enacted HB 442 (Appendix B) which amended the Code of Virginia, Title 38.2, by adding §38.2-3407.10. This section requires that insurers who include coverage for obstetrical or gynecological services permit any females age 13 or older direct access to the participating obstetrician-gynecologist of their choice. These insurers include health maintenance organizations. Therefore, HMOs who are contracted to provide services to Medicaid recipients in Medallion II or *Options* are subject to the mandate of this law. The law also recommends consultation and coordination between the primary care physician and the physician providing the obstetrical or gynecological services.

There are certain instances where the Department does limit freedom of access to providers. 42 CFR 431.54 (e) & (f) allows exceptions to freedom of choice of providers. Under certain conditions, when a recipient is found to utilize Medicaid services at a frequency or amount that is not medically necessary, the recipient may be restricted to a designated provider for a reasonable period of time. Additionally, if a provider is found to abuse the Medicaid program, the provider may be restricted from participating in the program for a reasonable period of time.

METHODOLOGY

Using claims with recorded procedural codes for obstetrical or gynecological services, the Department extracted claims data by provider and specialty for 1991 and 1994 to determine if there was any difference in utilization patterns by recipients. Those specific years were selected since 1991 was prior to the implementation of MEDALLION and 1994 was prior to implementation of *Options* and Medallion II. Since access to care is always a concern, the Department also tabulated current contracted providers by city/county to determine if there were areas with a low number of specific provider types.

FINDINGS

The city/county listing of providers indicates the central billing address the provider cites in the contract with the Department for payment of claims. The providers may serve additional cities or counties besides the central office site, but the Department does not gather that information. The Department has a variety of contracted providers who provide obstetrical and gynecological services. They include physicians; General Practitioners, OB/GYN, Internal Medicine, General Surgery, and Pediatric, as well as Nurse Midwives and Nurse Practitioners. Federally Qualified Health Centers, Health Department Clinics and Rural Health Clinics are also contracted with the Department and provide these services.

With the exception of King and Queen County, which only has a Health Department Clinic as a Medicaid provider, all other cities and counties have at a minimum a General Practitioner and most have a variety of the providers listed above.

The claims data for 1991 and 1994 included data on the specific provider accessed by the recipient, dollars reimbursed and total number of claims based upon the city or county where the recipient resides. Recipients were able to access a variety of the provider types listed above. Since the Department does not have specific clinic site information on all providers, we are unable to determine whether or not the recipient traveled outside their home county to access services. Claims were submitted by the provider types listed above.

The total of claims submitted and expenditures increased from 1991 to 1994, but there appeared to be no difference in provider types accessed in the two years reviewed. This would indicate that the requirement for a referral for gynecological services did not limit access to any particular provider.

RECOMMENDATIONS

The Department will be expanding enrollment in Medallion II into areas adjacent to Tidewater in November 1997, and into Northern Virginia in January 1998. As these expansions occur, the number of recipients enrolled in health maintenance organizations will increase.

The Department recommends that the MEDALLION regulations be amended to exclude gynecological services from the requirement for a referral. With this change, Medicaid recipients could access the provider of their choice for obstetrical and gynecological services including family planning without seeking a referral from their primary care physician. In making this change, Medicaid recipients would be allowed the same freedom of choice for these services that are available to the general public under private insurance and health maintenance organizations. This change may result in a slight savings to the Department since it will eliminate a possible visit to a primary care physician to obtain a referral to the obstetrical and gynecological specialist.

The changes in the MEDALLION regulations should include a requirement for consultation and coordination of services between the primary care physician and the physician providing the services as is contained in the language of HB442.

APPENDICES

HJR 598	A
HB 442	B

A copy of the data may be obtained from the Department's Public Information Officer at 804-786-3873.

Appendix A

House Joint Resolution 598 (1997)

HOUSE JOINT RESOLUTION NO. 598

Requesting the Department of Medical Assistance Services to study Medicaid recipients' direct access to obstetric and gynecological services.

Agreed to by the House of Delegates, February 4, 1997
Agreed to by the Senate, February 19, 1997

WHEREAS, in 1996, the General Assembly mandated direct access to obstetrical and gynecological services for female enrollees in private managed health care plans; and

WHEREAS, the Governor has included a similar provision in state employees' health care plans through an Executive Order; and

WHEREAS, the state Medicaid program is not required to comply with the statutory or Executive Order requirements; and

WHEREAS, an increasing number of Medicaid recipients have coverage available only through a health maintenance organization (HMO) or other plan that requires the primary care provider to be a "gatekeeper" for other health care services; and

WHEREAS, the specialty of obstetrics and gynecology is devoted to primary and preventive health care for women throughout their lifetimes; and

WHEREAS, significant numbers of women view their obstetrician-gynecologist as their primary or sole health care provider during their reproductive years; and

WHEREAS, the majority of women have visited their obstetrician-gynecologist during the past two years; and

WHEREAS, some managed health care plans that require a primary care physician referral to an obstetrician-gynecologist may cause women additional expense and inconvenience, and delay access to appropriate care; and

WHEREAS, 75 percent of those women who are required to have a referral for obstetrical and gynecological services report that they would like this requirement eliminated; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Medical Assistance Services be requested to study Medicaid recipients' direct access to obstetric and gynecological services. The Department shall determine the costs and benefits of allowing female Medicaid recipients direct access to obstetricians and gynecologists, and offer such recommendations as it may deem appropriate. During the course of study, the Department shall confer with the Virginia Obstetrical and Gynecological Society, the Virginia Chapter of the American College of Nurse Midwives, and the Virginia Council of Nurse Practitioners on the efficacy and appropriateness of allowing female Medicaid recipients direct assess to obstetrical and gynecological services.

All agencies of the Commonwealth shall provide assistance to the Department, upon request.

The Department shall complete its work in time to submit its findings and recommendations to the Governor and the 1998 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Appendix B

Chapter 967 of the 1996 Virginia Acts of Assembly (HB 442)

CHAPTER 967

An Act to amend and reenact §§ 38.2-4214 and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding in Article 1 of Chapter 34 of Title 38.2 a section numbered 38.2-3407.10, relating to accident and sickness insurance; access to obstetrician-gynecologists.

[H 442]

Approved April 17, 1996

Be it enacted by the General Assembly of Virginia:

1. That §§38.2-4214 and 38.2-4319 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Article 1 of Chapter 34 of Title 38.2 a section numbered 38.2-3407.10 as follows:

§38.2-3407.10. Access to obstetrician-gynecologists.

A. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) health maintenance organization providing a health care plan for health care services, whose policies, contracts or plans, including any certificate or evidence of coverage issued in connection with such policies, contracts or plans, include coverage for obstetrical or gynecological services, shall permit any female of age thirteen or older covered thereunder direct access, as provided in subsection B, to the health care services of a participating obstetrician-gynecologist (i) authorized to provide services under such policy, contract or plan and (ii) selected by such female.

B. An annual examination, and routine health care services incident to and rendered during an annual visit, may be performed without prior authorization from the primary care physician. However, additional health care services may be provided subject to the following:

(i) consultation, which may be by telephone, with the primary care physician for follow-up care or subsequent visits;

(ii) prior consultation and authorization by the primary care physician, including a visit to the primary care physician, if determined necessary by the primary care physician before the patient may be directed to another specialty provider; and

(iii) prior authorization by the insurer, corporation, or health maintenance organization for proposed inpatient hospitalization or outpatient surgical procedures.

C. For the purpose of this section, "health care services" means the full scope of medically necessary services provided by the obstetrician-gynecologist in the care of or related to the female reproductive system and breasts and in performing annual screening and immunization for disorders and diseases in accordance with the most current published recommendations of the American College of Obstetricians and Gynecologists. The term includes services provided by nurse practitioners, physician's assistants, and certified nurse midwives in collaboration with the obstetrician-gynecologists providing care to individuals covered under any such policies, contracts or plans.

D. Nothing contained herein shall prohibit an insurer, corporation, or health maintenance organization from requiring a participating obstetrician-gynecologist to provide written notification to the covered female's primary care physician of any visit to such obstetrician-gynecologist. Such notification may include a description of the health care services rendered at the time of the visit.

E. Each insurer, corporation or health maintenance organization subject to the provisions of this section shall inform subscribers of the provisions of this section. Such notice shall be provided in writing.

F. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered,

issued for delivery, reissued, renewed, or extended or at any time when any term of any such policy, contract, or plan is changed or any premium adjustment is made. The provisions of this section shall not apply to short-term travel or accident-only policies, or to short-term nonrenewable policies of not more than six months' duration.

§38.2-4214. Application of certain provisions of law.

No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§38.2-200, 38.2-203, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-232, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§38.2-1300 et seq.) and 2 (§38.2-1306.2 et seq.) of Chapter 13, 38.2-1312, 38.2-1314, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3405.1, 38.2-3407.1 through 38.2-3407.6, 38.2-3407.9, *38.2-3407.10,* 38.2-3409, 38.2-3411 through 38.2-3419.1, 38.2-3425 through 38.2-3429, 38.2-3431, 38.2-3432, 38.2-3500, 38.2-3501, 38.2-3502, 38.2-3514.1, 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§38.2-3525, 38.2-3540.1, 38.2-3541, 38.2-3542, 38.2-3600 through 38.2-3607 and Chapter 53 (§38.2-5300 et seq.) of this title shall apply to the operation of a plan.

§38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§38.2-100, 38.2-200, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§38.2-900 et seq.) of this title, 38.2-1057, 38.2-1306.2 through 38.2-1309, Article 4 (§38.2-1317 et seq.) of Chapter 13, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6, 38.2-3407.9, *38.2-3407.10,* 38.2-3411.2, 38.2-3418.1, 38.2-3418.1:1, 38.2-3418.2, 38.2-3419.1, 38.2-3431, 38.2-3432, 38.2-3433, 38.2-3500, 38.2-3514.1, 38.2-3525, 38.2-3542, and Chapter 53 (§ 38.2-5300 et seq.) of this title shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance organization.

B. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

C. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

D. Notwithstanding the definition of an eligible employee as set forth in §38.2-3431, a health maintenance organization providing health care plans pursuant to §38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.