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Addressing STIs Through Managed Care: Opportunities in Medicaid and Beyond

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Abstract

The US is facing a growing epidemic of sexually transmitted infections (STIs), with over 2.5 million cases of chlamydia, gonorrhea, and syphilis reported in 2021 and again in 2022. This public health crisis disproportionately affects youth and racial and ethnic minority communities, exacerbating barriers to accessing sexual health services. Untreated STIs can lead to severe health consequences, including infertility, pelvic inflammatory disease, and increased risk of HIV transmission and acquisition. Managed care organizations (MCOs) within Medicaid play a pivotal role in improving sexual health service delivery and addressing the rise in STIs.

This commentary explores opportunities for Medicaid MCOs to enhance STI prevention, screening, and treatment. It was informed by reviews of Medicaid managed care contracts, plan

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provider manuals, and interviews with Medicaid plan officials and other experts. It presents a set of opportunities to enhance STI prevention, including incentivizing syphilis screening during pregnancy through existing perinatal and maternal health efforts, leveraging extended postpartum coverage for sexual health education, integrating STI services with substance use disorder programs, supporting community-based organizations that serve relevant communities, training community-facing workers in STI care and sexual health, coordinating with local health departments, and providing enrollee access to condoms and home STI tests.

Implementing these strategies could reduce STI rates and improve health outcomes, particularly among vulnerable populations. Although this commentary draws on research focused on Medicaid MCOs, a coordinated approach that includes commercial plans and coordination with health departments could ultimately enhance the consistency and quality of STI services and sexual health care across the health care system.

The US is experiencing an epidemic of sexually transmitted infections (STIs). Over 2.5 million cases of chlamydia, gonorrhea, and syphilis were reported in the US in 2022 alone (Figure 1¹).² STIs disproportionately affect youth, with half of chlamydia, gonorrhea, and syphilis infections diagnosed among people aged 15 to 24 years.² Additionally, racial and ethnic minority communities experience higher barriers to accessing sexual health services and disparate levels of community risk.² Untreated chlamydia or gonorrhea can result in female pelvic inflammatory disease, infertility, or ectopic pregnancy, and STIs increase the likelihood of HIV transmission or acquisition.^{3,4}

Soaring rates of syphilis are of particular concern.⁵ Untreated syphilis can attack the nervous, visual, and auditory systems at any stage of infection. In a small subset of cases, late-stage syphilis can affect multiple organ systems, potentially causing blindness and hearing loss.⁵

Rates of primary and secondary syphilis in women rose nearly 20% from 2021 to 2022.² In parallel with this ongoing trend, cases of congenital syphilis have grown sharply (Figure 2²).² Congenital syphilis causes stillbirths and infant deaths, and babies born with congenital syphilis can experience seizures, developmental delays, and other complications.⁵ The economic costs of treating a case of congenital syphilis can be remarkably high, with one source reporting that in 2016, the average cost of hospitalization alone was over \$120,000.⁶

Fortunately, bacterial STIs are treatable, and their worst sequelae, including congenital syphilis, can be prevented. The challenge lies in ensuring that the health care system reaches people with appropriate screening, diagnosis, and treatment.

Medicaid already plays a crucial role in this space, insuring 40% of children and 12% of adults aged 19 to 26 years,⁷ covering a disproportionate share of sexual health visits nationwide,⁸ and paying for 41% of all births.⁹ Managed care's role is particularly important: over 73% of total Medicaid enrollees are in managed care plans, as are 85% of children and 82% of adults who became eligible due to Medicaid expansion.¹⁰

With support from the CDC's Division of STD Prevention and building on earlier work,^{11–14} we conducted an analysis to identify opportunities for Medicaid managed care organizations

(MCOs) to strengthen their response to bacterial STIs and promote sexual health. The recommendations below were informed by a review of all state Medicaid managed care model contracts and interviews with state and national Medicaid MCO plans and sexual health services experts (eAppendix Table [eAppendix available at ajmc.com]). Although rooted in an analysis of Medicaid, many of these steps also represent important opportunities for commercial health plans to address STIs among their enrollees.

Incentivize Syphilis Screening in Existing Perinatal Health Improvement Initiatives

Prevention of congenital syphilis requires identification and treatment of syphilis in pregnancy. The CDC¹⁵ and the American College of Obstetricians and Gynecologists (ACOG) recommend routine syphilis screening in the first trimester,¹⁶ and until recently, both also recommended that screening in the third trimester and at delivery be based on risk. Meanwhile, state laws regarding syphilis testing in pregnancy vary.¹⁷

The lack of a national recommendation (or Healthcare Effectiveness Data and Information Set [HEDIS] measure) has not entirely precluded action at the state or plan level. For example, in 2020, AmeriHealth Caritas Louisiana created a perinatal quality enhancement program that included syphilis screening in the third trimester.¹⁸ Louisiana Medicaid then developed a required Performance Improvement Project (PIP) with specific targets for increasing syphilis screening at all 3 stages, which offers a compelling model for other states and plans.¹⁹ Louisiana recently launched the PIP with all 6 of its state MCOs; they focus on both patient and provider engagement.

However, in interviews with Medicaid MCOs and in earlier interviews with health care providers,¹⁸ we heard repeatedly that the lack of a national recommendation made it difficult to shift providers to routine third-trimester and delivery screening.

This landscape recently changed. In April 2024, citing nationally rising rates of congenital syphilis and persistent disparities, ACOG revised its recommendation to endorse routine screening in the first and third trimesters and at delivery.²⁰ Accordingly, Medicaid MCOs, in partnership with state Medicaid agencies, may consider recommendations for their providers to conduct routine syphilis screenings in the first and third trimesters and at delivery, whether through reporting requirements, performance incentives, or both.

Many Medicaid contracts already require a range of activities around pregnancy, including specific quality improvement efforts or care management,²¹ and every plan we interviewed discussed focused efforts to improve perinatal health. Syphilis testing can be integrated into these efforts. Where states or MCOs use bundled payments for prenatal care, they could consider either a carved-out reimbursement or a bonus for syphilis screening.

Most of the plan representatives we interviewed described extensive provider and enrollee education around pregnancy and providing case management to higher-risk enrollees. All such initiatives could include information about syphilis screening in pregnancy and use existing enrollee incentives to support education and uptake of syphilis screenings.

Leverage the New Longer Postpartum Coverage Period

All but 1 state have either extended, or plan to extend, postpartum Medicaid coverage from the minimum 60 days to 12 months.²² The health plans we looked at are starting to consider how to best use this opportunity to strengthen their postpartum health efforts. During the postpartum period, MCOs could encourage or incentivize providers to provide counseling regarding sexual health and STIs; plans could also offer enrollee education on STIs and sexual health.

Address Sexual Health Alongside Substance Use Services

Syphilis rates among heterosexual men and among women, pregnant women in particular, are strongly associated with substance use, including methamphetamine, heroin, and other injection drugs.^{23,24} All Medicaid MCO efforts serving enrollees with substance use disorder could include low-barrier testing and treatment for syphilis and other STIs. Notably, Indiana's model contract requires plans to cover opioid treatment programs that include syphilis, HIV, and hepatitis testing.²⁵

Support Relevant Community-Based Providers

Most plans fund community-based organizations through grants and other mechanisms.²⁶ The plan representatives we interviewed were enthusiastic about these opportunities to bolster the capacity of clinical safety net providers and address social determinants of health through nonclinical organizations.

To support meaningful access to STI services, MCOs can identify trusted local organizations that serve communities highly affected by STIs, such as organizations focused on lesbian, gay, bisexual, transgender, and queer or questioning populations or those serving birthing communities of color. Funding education or outreach opportunities through such organizations could support public health by fostering greater trust in the health care system and utilization of sexual health and other services. MCOs could also sponsor on-site STI testing opportunities, which could help bolster chlamydia HEDIS screening rates while promoting community health.

Train Community-Facing Workers on STIs

Many MCOs, including those we looked at, employ or reimburse community health workers, prenatal and postpartum doulas, and other frontline workers who conduct outreach, education, and linkages to care.¹⁹ All of these workers could be trained to inform enrollees on where to seek STI screening and treatment services and where partners, whether insured or not, can receive free or low-cost services. These workers should also be trained to counsel enrollees that STI testing and treatment are “family planning–related” services for which Medicaid enrollees may see any Medicaid provider regardless of whether they are in their plan's network under federal law.

Coordinate With Local Health Departments

Local health departments serve a central role in addressing STIs by conducting surveillance, partner notification, contact tracing, and education services. Most STI clinics in the US are run by health departments,²⁷ and many bill both Medicaid and private insurance.²⁸ Notably, 12 states' model contracts require plans to reimburse local health departments for STI testing and other services. Some states specifically direct plans to coordinate with local health departments regarding STI screening, partner notification, and follow-up. Whether or not contractually required, MCOs can reach out to local health departments in their service areas to coordinate with community-level STI efforts. MCOs can also give local health departments funding to support disease intervention specialists who address individual health and minimize community transmission.

Provide Member Access to Condoms and Home STI Tests

Condoms and home STI tests are over-the-counter (OTC) products that play important roles in STI prevention. Some state Medicaid programs are already covering OTC contraceptive products including condoms,²⁹ and the 2023 approval of the first OTC birth control pill has further heightened interest in OTC coverage.³⁰ The approaches that states and plans develop to provide OTC birth control and other products to Medicaid enrollees could also be applied to increase access to condoms and home STI tests.

CONCLUSION

Although some of these opportunities, such as the extended postpartum eligibility period, are specific to Medicaid, many of these approaches could be taken up by other public and commercial health plans. Consistent multipayer efforts—in parallel or, ideally, in collaboration—would not only improve enrollee health but also standardize payment models to facilitate consistent care by providers. Regardless of sector, managed care plans have an important role to play in reversing the tide of congenital syphilis and other STIs.

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Appendix: Interviewees

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State Medicaid Program

Shantel Hebert-Magee, MD, MPH, Chief Medical Officer, Medicaid, Bureau Health Services Financing, Louisiana Department of Health

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Arethusa Kirk, MD, FAAP, Vice President of Population Health & Clinical Strategy, United Healthcare

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Blair Harrison, MPH, Policy Director of National Population Health and SocialCare, United Healthcare

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State Medicaid MCO Medical Directors

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Nadim Kanafani, MD, MPH, Plan Performance Medical Director, Missouri Healthy Blue

Krishnan N. Subrahmanian, MD, MPhil, FAAP, Chief Medical Officer (CMO), Hennepin Health Minnesota

State Medicaid MCO Administrators

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Kimberly Buttermore, MSN, RN, RNC-MNN, Director of Clinical Programs, Maternity and Pediatric Care Management, University of Pittsburgh Medical Center (UPMC) Health Plan

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Annette Baumann, Quality Manager, Hennepin Health Minnesota

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Dorinda Hunter, MBA, Care Management Lead for Maternal Health, Sentara Health, Virginia

Todd White, Chief Executive Officer, Aetna Better Health of West Virginia

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TAKEAWAY POINTS

This commentary discusses how Medicaid and other managed care organizations could strengthen their response to the current epidemic of sexually transmitted infections (STIs), preventing morbidity, infertility from various STIs, and deaths from congenital syphilis. Opportunities include the following:

- Promoting routine syphilis screening during pregnancy through existing perinatal health initiatives.
- Leveraging the new postpartum extension period to promote sexual health.
- Supporting community-based organizations and workers to improve access and trust in sexual health services.
- Integrating STI services with substance use disorder programs.
- Coordinating with local health departments to support individual and community STI services.
- Identifying ways to provide over-the-counter STI tests and condoms to enrollees.

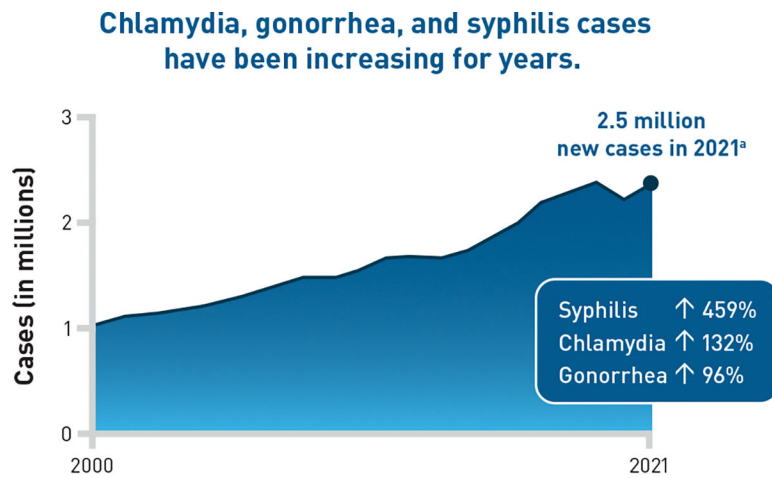


FIGURE 1.

Increases in Overall Incidence of Bacterial STIs¹

STI, sexually transmitted infection.

^a2020 and 2021 data reflect the effect of COVID-19 on STI surveillance trends.

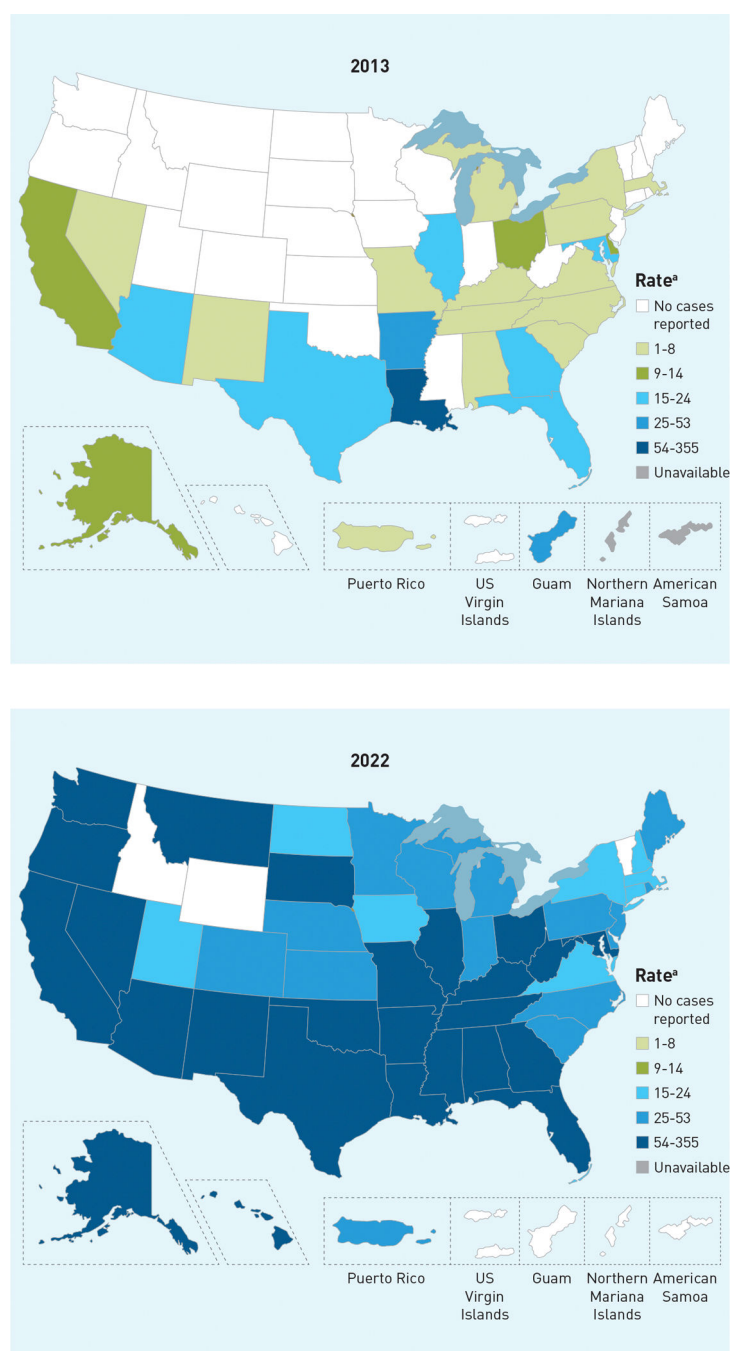


FIGURE 2.
 Congenital Syphilis: Rates of Reported Cases by Year of Birth and Jurisdiction, US and Territories, 2013 and 2022¹
^aPer 100,000 live births.