Doing More for Less: Study Says State Medicaid Family Planning Expansions Are Cost-Effective

By Rachel Benson Gold

The past four years have been excruciatingly difficult ones for state governments—in terms of their budgets in general and for their Medicaid programs in particular. According to a new survey by the Kaiser Commission on Medicaid and the Uninsured, every state in the country save one either has implemented Medicaid cost-containment strategies in the current fiscal year or plans to do so. According to Health Management Associates' Vern Smith, one of the authors of the report, the situation is not likely to improve anytime soon. "We know that 2003 and 2004 were two of the worst years financially for state Medicaid programs since [the program's] inception nearly forty years ago," says Smith, "and 2005 could be just as bad from the states' perspective."

Against this backdrop, the findings of the first-ever national evaluation of state-initiated programs *expanding* eligibility for Medicaid-covered family planning services are particularly significant. The evaluation—commissioned by the federal Centers for Medicare and Medicaid Services (CMS), the agency that administers Medicaid—found that every one of the expansion programs it studied not only met the federal requirement that they not result in additional costs to the federal government, but actually saved money. Although saving public funds while expanding government services is laudable at any time, finding a way to do so is particularly significant at a time when states are otherwise feeling the need to make painful Medicaid program cuts.

MEDICAID FAMILY PLANNING WAIVERS	
EXTENDING ELIGIBILITY TO INDIVIDUALS...	
LOSING COVERAGE...	BASED SOLELY ON INCOME
POSTPARTUM	ALABAMA (133% OF POVERTY)
ARIZONA (2 YEARS)	ARKANSAS (200%)
FLORIDA (2 YEARS)	CALIFORNIA (200%)
MARYLAND (5 YEARS)	MISSISSIPPI (185%)
MISSOURI (1 YEAR)	NEW MEXICO (185%)
RHODE ISLAND (2 YEARS)	NEW YORK (200%)
VIRGINIA (2 YEARS)	OREGON (185%)
FOR ANY REASON	SOUTH CAROLINA (185%)
DELAWARE (2 YEARS)	WASHINGTON (200%)
ILLINOIS (5 YEARS)	WISCONSIN (185%)

State Waiver Programs

Over the past decade, 18 states have obtained federal approval, known as waivers, to extend eligibility for Medicaid-covered family planning services to individuals who would otherwise not be eligible for such care. In general, states have taken one of three approaches to their programs.

Under federal law, states are required to cover pregnancy-related care, including family planning services, for 60 days postpartum for women with incomes up to 133% of the federal poverty level—far above states' regular Medicaid eligibility ceilings. Six states extend the postpartum period for family planning services for one to five years (see box). Two states extend family planning coverage to women who leave Medicaid for any reason. And 10 states take a far bolder approach by granting Medicaid coverage for family planning solely on the basis of income to women not previously covered under Medicaid at all, in most cases to all women in the state with incomes up to 185% or 200% of the federal poverty line ($15,670 for a family of three in 2004). Four of these family planning expansion programs also cover men.

According to reports provided to The Alan Guttmacher Institute, 12 of the 13 states with waiver programs operating in 2001 provided contraceptive services (as well as testing for cervical cancer, sexually transmitted infections and HIV) to 1.7 million clients that year. Nearly 1.3 million people were served in the massive California program alone ("Medicaid Family Planning Expansions Hit Stride," *TGR,* October 2003, page 11).

Saving Money, Improving Access

The CMS study was conducted by the CNA Corporation along with researchers from Emory University and the University of Alabama at Birmingham. It first looked at six state waiver programs (in Alabama, Arkansas, California, New Mexico, Oregon and South Carolina) to determine whether they met the federal requirement for budget neutrality—that is, that federal spending under the waiver not exceed what federal spending would have been without the waiver. Using what they deemed to be the most appropriate method for calculating budget neutrality, they found that all six programs resulted in often substantial net savings (see table, page 2). For example, the South Carolina program realized total savings of $56 million over a three-year period starting in 1994, while Oregon's program saw savings of nearly $20 million in a single year; these savings were split between the federal and state governments, based on a formula established by CMS for calculating the federal share of Medicaid costs.

[Interestingly, corroboration for the CMS cost-savings finding came

recently from Wisconsin, but for an unlikely reason. Since 2002, Wisconsin has had a waiver to provide family planning services to all women in the state with incomes up to 185% of poverty. A bill is pending in the state legislature to limit coverage under the waiver to individuals aged 18 and older. A cost estimate for the provision developed by the Wisconsin Department of Administration indicated that denying care to individuals 15–17 would result in more than 3,300 additional births to teens in the state, at an additional cost of $12.7 million in public funds, over a five-year period.]

In addition, the CMS study found that even as they saved money, the waivers increased access to services. In four of the six states, the number of clients served in clinics receiving funds through the Title X program who met the eligibility requirements for the waiver grew after the program was implemented. Geographic availability of services increased in all states, and two states demonstrated significant use of private-sector as well as family planning clinic–based services. Finally, the study found evidence in two states of a measurable reduction in unintended pregnancy among the total population of women eligible for the waiver—a very high bar for the program to clear, according to the researchers.

Learning from Experience

The CMS study findings have important implications for policymakers at the federal and state levels as well as for reproductive health advocates.

Let the states decide. As a matter of federal policy, waiver programs are time-limited "research and demonstration" initiatives designed to test innovative strategies for providing cost-effective care to Medicaid enrollees. The study results showing a combination of cost-savings with improved access provide convincing evidence that the family planning waivers have demonstrated what they were designed to test. The Family Planning State Empowerment Act, jointly sponsored by Sens. Lincoln Chafee (R-RI) and Dianne Feinstein (D-CA), would give states the authority to expand Medicaid family planning eligibility on their own, without having to go through the process of obtaining a federal waiver—widely acknowledged to be cumbersome at best and prohibitive at worst. A similar provision is included in the Improving Women's Health Act, sponsored by Sen. Blanche Lincoln (D-AR), as well as in the Prevent Prematurity and Improve Child Health Act, sponsored by Sens. Lincoln, Richard G. Lugar (R-IN) and Jeff Bingaman (D-NM).

Federal Medicaid policy has turned this corner before. Throughout the 1980s, CMS granted a number of states waivers to establish demonstration programs designed to test the feasibility of providing Medicaid services in a managed care environment. In 1997, with programs firmly established across the country, Congress moved to allow states to amend their state Medicaid plans and mandate managed care enrollment without having to seek federal permission to do so.

At a minimum, the study provides a roadmap for CMS to streamline the waiver process by giving states a uniform formula for asserting budget neutrality that is agreed upon in advance. This could significantly reduce the length of time between an application's submission and its approval—a lag that stretched to more than 16 months in the case of Illinois, the last family planning waiver to be approved.

Bigger is better. The CMS study findings have significant relevance for policymakers at the state level as well. In harsh economic times, when the states are feeling compelled to make difficult choices about their Medicaid programs, an effort that can reduce costs while actually improving access to care for enrollees may be particularly attractive. Because family planning services are cost-effective,

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IMPACT OF MEDICAID FAMILY PLANNING WAIVERS

State	Year	Births Averted	Net Savings (in 000s)		
			Total	State Share*	Federal Share
Alabama	2000–2001	3,612	$19,029	$6,982	$12,047
Arkansas	1997–1998	2,748	15,524	5,199	10,325
	1998–1999	4,486	29,748	9,412	20,336
California	1999–2000	21,335	76,183	64,314	11,868
New Mexico	1998–1999	507	1,334	653	682
	1999–2000	1,358	5,009	2,038	2,972
	2000–2001	1,528	6,511	2,650	3,860
Oregon	2000	5,414	19,756	11,078	8,679
South Carolina	1994–1995	2,228	13,634	4,135	9,499
	1995–1996	3,151	19,616	6,202	13,414
	1996–1997	3,769	23,067	7,403	15,663

*State share of savings calculated by The Alan Guttmacher Institute, based on the total savings and the federal share of savings in the final report by the CNA Corporation.
Source: Edwards J, Bronstein J and Adams K, *Evaluation of Medicaid Family Planning Demonstrations,* Virginia: The CNA Corporation, 2003.

Waivers…
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the more people eligible to receive services, the greater the savings to the federal government and to the states. According to the CMS study, programs "that cover all low-income women, for example, will likely reach more of the expansion-eligible women in a given year than those that cover only post-partum women. Given the eligibility structure of the demonstration, a higher enrollment of uninsured eligible women and a greater use of effective contraceptive services will lead to a greater likelihood that the state will see an effect on unwanted pregnancies." Accordingly, the eight states that have tailored their waiver programs more narrowly to women losing Medicaid coverage may want to reassess the scope of their efforts. Similarly, in light of the study results from Wisconsin, those states that are considering barring teenagers from eligibility under their programs may want to think twice before doing so.

Streamlining enrollment. The California Family PACT program includes a unique feature designed to address a long-standing and widely acknowledged problem in Medicaid—its cumbersome and time-consuming enrollment process. Under Family PACT, clients are enrolled at the family planning clinic, for example, rather than having to apply in person at a welfare office. So-called point-of-service eligibility obviates the need for a client to make multiple visits and avoids the stigma of an association with welfare; moreover, clients are able to access services immediately. The CMS study looked at the proportion of individuals eligible for the waiver programs in the various states who actually obtained family planning care. It found that in California, 48% of eligible individuals utilized services, more than twice the level reported in other states. While the study does not assert a causal relationship between provider-determined eligibility in California and utilization levels, it should give policymakers in other states food for thought.

Looking beyond Medicaid. Finally, the CMS study provides important corroborative evidence for a long-standing assertion of reproductive health advocates: that providing additional resources for high-quality family planning services is a wise policy choice, especially in difficult economic times, because it expands access to a service people want and need to improve their own health and well-being *and* it saves taxpayers money. In that way, the study could provide important new impetus for advocates and policymakers at both the federal and state levels to find some much-needed common ground. ⊕

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