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Breaking New Ground: Ingenuity and Innovation In Medicaid Family Planning Expansions

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Through three waves of expansions spanning more than two decades, Medicaid has opened its doors to large numbers of women and children whose low family incomes were nonetheless too high to meet the strict eligibility requirements for the Medicaid program. In implementing these expansions, policymakers and providers in states and communities across the country have confronted myriad challenges in their efforts to enroll and serve newly eligible groups. Expansions of Medicaid eligibility for family planning, the newest of these expansions, have both built upon these earlier efforts and broken critical new ground on issues that have bedeviled policymakers and providers for years. In many ways, this progress has come through developing new and unique partnerships between state programs and providers, and by finding creative ways to leverage state dollars and funding through the federal Title X program.

Two Decades of Expansion

When Medicaid was first established in 1965, the low-income families covered by the program generally were headed by single mothers receiving welfare benefits. In the 1980s, Congress broke the welfare-Medicaid link by first allowing and later requiring states to extend eligibility for Medicaid-covered pregnancy-related care (including postpartum family planning services) to women with incomes up to 133% of the federal poverty level—far above most states' regular Medicaid eligibility ceiling. At their option, states could expand eligibility for pregnancy-related services to women with incomes up to 185% of poverty or beyond, and 39 states and the District of Columbia currently do so.

Following the demise of broad-based health care reform in the early 1990s, Congress embarked on an incremental strategy toward universal insurance coverage, by improving coverage for one population group at a time. Key to this approach was the enactment in 1997 of the State Children's Health Insurance Program (SCHIP). This program, a companion to Medicaid, is aimed at providing coverage for children in families with an income up to 200% of poverty, although some states have extended coverage well beyond that level.

With these earlier expansions as a model, more than half the states have moved to expand eligibility specifically for family planning. Three-quarters of the U.S. women estimated to be in need of publicly subsidized contraception live in one of the 26 states that have some form of expanded Medicaid family planning eligibility. To expand eligibility, states must obtain approval via a research and demonstration "waiver" from the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the Medicaid program.

Such waiver programs take three approaches. The first built directly on the expansions for pregnancy-related care, which allow states to provide Medicaid-funded family planning, as part of postpartum care, for 60 days after a woman gives birth. Four states currently have federal approval to continue coverage for family planning services, generally for two years postpartum. The second route, utilized by Delaware and Florida, is a variation on this approach. These states continue Medicaid family planning coverage for individuals who leave the Medicaid program for any reason.

The third and boldest approach taken by states is to extend Medicaid family planning coverage based on income rather than on previous participation in the program, opening coverage to residents with no previous association with the program at all. Twenty states have instituted these broad-based expansions, with most extending coverage to individuals with an income at or near 200% of the poverty level (see box).

Research on the impact of these programs—and particularly the impact of the broad income-based efforts—is accumulating. The efforts have been shown to broaden private physician participation in the provider network; improve geographic availability of services; extend the interval between pregnancies; expand the number of family planning clients; help women avoid unplanned pregnancies, unplanned births and abortions; and reduce teen pregnancies, births and abortions. And according to federal and state evaluations, as well as independent studies, these efforts generate substantial cost savings to both the federal and state governments.

The success of these programs stems in no small measure from the numerous decisions, large and small, by policymakers and providers that have shaped the various expansions and affected how they are perceived and utilized by family planning clients, health care providers and state officials. These decisions have both built upon the lessons from earlier Medicaid expansions and broken critical new ground. To gain a better understanding of the innovations in program design and best practices in operation, the Guttmacher Institute hosted a meeting in late 2007 with state officials responsible for implementing income-based family planning expansions. Officials from 15 of 20 states with such programs participated in the discussion, with officials from four of the remaining states providing information subsequent to the meeting. These state officials identified the challenges associated with implementing and maintaining family planning expansions and the solutions crafted in response. Those discussions and the report that emerged from them, *State Government Innovation in the Design and Implementation of Medicaid Family Planning Expansions,* are the basis for most of this article.

INCOME-BASED PROGRAMS

Twenty states have expanded eligibility for Medicaid family planning services to individuals based solely on their income.

State	Income Ceiling
Alabama	133% of poverty
Arkansas	200%
California	200%
Illinois	200%
Iowa	200%
Louisiana	200%
Michigan	185%
Minnesota	200%
Mississippi	185%
New Mexico	185%
New York	200%
North Carolina	185%
Oklahoma	185%
Oregon	185%
Pennsylvania	185%
South Carolina	185%
Texas	185%
Virginia	133%
Washington	200%
Wisconsin	200%

Reaching Out

The expansions for pregnant women pioneered what was for Medicaid a wholly new emphasis: actively reaching out to potential clients in an attempt to locate and enroll in the program as many eligible people as possible. From the outset, the federal government reimbursed states for outreach activities, such as targeted mailings and telephone hotlines, in an effort to increase prenatal coverage. States used creative program names, such as RIte Start in Rhode Island, to disassociate the program from the stigma often attached to welfare and Medicaid. Years later, SCHIP programs made use of similar outreach efforts.

The family planning expansions have built upon this foundation. In the process, they have developed important innovations of their own, including a focus on program Web sites. For example,

California's site includes fact sheets in 11 languages, and the Illinois site includes a picture of an enrollment card, so women will know what to look for in the mail. And almost all states' Web sites include provider maps and a zip code locator to help clients find providers in their area.

At the same time, programs have segued toward more focused and directed outreach. Programs use mailing and telephone calls to reach out to postpartum women leaving Medicaid. Several states are making concerted efforts to reach potential family planning clients enrolled in a broader set of public programs. Outreach personnel in Alabama, for example, contact women receiving food stamps or WIC (the supplemental nutrition program for women, infants, and children), and they include information on the family planning effort in the packets sent out at the beginning of the school year to parents of children enrolled in Head Start.

Reaching out to individuals who are not already receiving public benefits is even more challenging. In states such as Minnesota and Oklahoma, programs work directly with college health centers to reach potentially eligible students. In others, special efforts are made to reach out to Latinas, because of their relatively high rates of unintended pregnancy, relatively low rates of private insurance coverage and potential language barriers. Texas, for example, has produced bilingual outreach materials and plans to test Spanish-language transit ads.

Local outreach teams also reach out to vulnerable members of their own community. In Louisiana, state outreach staff contact potential clients at hospitals and clinics, physicians' offices, pharmacies, colleges, churches, large companies and state fairs. Although statewide efforts are often funded either through the family planning expansion itself or with other state dollars, local-level efforts are often directed and funded by local family planning providers, frequently with Title X dollars.

States have also placed a heavy emphasis on reaching out to providers. In many states, Medicaid providers are automatically eligible to serve family planning expansion clients, and billing and enrollment procedures are integrated into the overall Medicaid program. Other states, however, must reach out to enroll providers individually. In either case, states must educate providers about the program and its requirements and processes. Many states do this through printed materials and by working with provider groups, such as the state medical society or primary care association; increasingly, states are making use of the Internet for both initial and ongoing provider training.

Welcoming People In

The pregnancy-care expansions of the 1980s made important advances in streamlining the cumbersome Medicaid enrollment process, which had been widely acknowledged as deterring clients from seeking services. Application forms were shortened dramatically and made available at sites not associated with welfare, such as clinics and hospitals. Procedures were adjusted to allow for quicker processing in more neutral settings, avoiding the need for an in-person interview at a local welfare agency.

SCHIP programs aimed to further reduce enrollment barriers. States developed universal applications for a range of government programs and expedited, "express lane" enrollment that relieves families from having to demonstrate proof of their income a second time, if they had done so recently to receive welfare cash assistance, food stamps or WIC. Permitting clients to self-declare their income without providing verifying documents—often with after-the-fact checks via government databases—has lessened enrollment barriers.

Both the pregnancy-care expansions and the SCHIP program seized upon the importance of providing services to women and children in conjunction with their application, at the point of service. Family planning expansion programs have incorporated many of these strategies and in several key respects have carried them a step further. Family planning expansion programs in many states have eliminated the application entirely for certain groups of enrollees. Most frequently, a woman who would otherwise lose

Medicaid coverage after giving birth is automatically enrolled in the state's family planning expansion. Some states, moreover, automatically move a woman from the family planning program to the state's program for prenatal, delivery and postpartum care in the event that she becomes pregnant.

Among the biggest advances of the family planning programs are the efforts in three states to pioneer an innovative way to expedite the application process. These three states allow clients to sign up for family planning coverage at the point of service, receive services and—for the first time in a Medicaid program—leave their provider's office officially enrolled in the program. California, Iowa and Oregon all have some variation of this same-day, point-of-service enrollment.

Significantly, clinic staff do not make the actual eligibility determination. Rather, specially trained clinic personnel walk a client through the application, verify whatever documentation is required and enter the client's information into the state's computer system. During the client's visit, the system determines whether the client is eligible and issues a decision. In California, the client actually leaves with an enrollment card in hand. In Iowa, the card is generated centrally and sent to the mailing address designated by the client. Oregon does not issue enrollment cards.

Whether or not a client may enroll directly at the point of service, most state family planning expansions permit the application to be completed at the clinic. Although applying at the point of service is critical to encouraging people to enroll, it also puts a strain on clinic staff and finances. To mitigate that impact, four states are reimbursing providers for the cost of assisting clients with the application process. For example, Washington has developed a distinct code that providers may use to bill for application assistance to clients, such as explaining the application process, verifying information and entering it into the database. Taking a different approach, Oregon updated the reimbursement rate it provides to clinics for each family planning visit to account for the increased cost to clinics of helping clients meet the new citizenship documentation requirement in the application process.

Partnering with Providers

The family planning expansions have been enormously successful in bringing large numbers of potential clients to clinics for care. Guttmacher Institute data from 2001 show that clinics in states with income-based Medicaid expansions were able to serve 50% of the women in need of publicly funded contraceptive services, while clinics in states without expansions served just 40%. Moreover, only the expansion states, collectively, showed improvement in meeting the need for services between the mid-1990s and 2001. Along with boosting clinics' ability to meet the need for services, however, the expansions present significant challenges for providers.

Although the expansions may bring in large numbers of new clients to family planning providers, not all will be eligible for enrollment in the program. Clinics subsidized to any extent by Title X funds are required by the program to serve all who come to them for care, whether or not they have a source of coverage. For individuals not eligible under the Medicaid expansions—such as recent legal immigrants and those who entered the country illegally—clinics can be left scrambling to find the resources to serve them.

In an attempt to cover at least some of this potential shortfall, California, for instance, uses state funds to cover the cost for residents whose care is not eligible for federal reimbursement. In addition, Washington uses state funds to pay for 10 months of additional postpartum family planning for noncitizens ineligible for federal funding; Oregon, Pennsylvania and Wisconsin pay for clients' initial visit in some cases.

A second issue for providers concerns Medicaid reimbursement levels, which are determined individually by each state. Reimbursement rates under the various family planning expansions are almost invariably the same as under the broader Medicaid program. Roughly half of the states with expansions adjust their Medicaid rates on an ad hoc basis, depending on state finances and politics. In many states, this can

result in years-long stretches where rates are left untouched, not even adjusted to keep up with inflation.

Some states, however, have taken steps to keep reimbursement levels more evenly matched to the rising costs of providing care, often at the behest of the provider community. In 2007, two states, California and Minnesota, in which family planning reimbursement rates had been stagnant for years moved to increase their payments. Other states have established a process for scheduled, periodic rate increases, such as tying them to changes in federal Medicare payments or to the cost of delivering care. And, as the amount of time providers spend assisting clients with applications and counseling on family planning increases, a few states have targeted funds specifically to these activities.

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A third critical issue for providers concerns the scope of the package of covered services. In general, Medicaid will cover the basic services routinely provided in the course of a family planning visit. Although the details differ from state to state, this usually includes client counseling and education, contraceptive drugs and devices, and related diagnostic tests, such as testing for cervical cancer, pregnancy and STIs. But for some Medicaid enrollees, that basic package is not sufficient.

Coverage of STI treatment, especially, varies considerably across family planning waiver programs: Some expansions do not pay for treatment of any STIs, although others pay for a wide range. In some cases, the Medicaid expansion may not cover the cost of HIV testing. States have attempted to address these issues in a variety of ways. A few have set aside funds specifically for the treatment of STIs when these services are not included in the Medicaid expansion, as well as to cover treatment for a client's sexual partners. In others, providers may have no recourse but to use funds from programs such as Title X to fill in the gap.

Equally important, if not more so, the Medicaid expansions (and Medicaid generally) will pay only for the routine counseling provided as part of a standard family planning visit. Many clients, such as women who are homeless or have substance abuse issues, need more extensive counseling. Similarly, young women— especially those who are having their first Pap test or who are seeking contraception for the first time— often need more extensive counseling.

Here again, providers look to Title X and other flexible funding sources, such as state funding, to fill in the gap. In the process, the family planning expansions are forging a new and beneficial synergy between Medicaid and Title X, with Medicaid funding the core of the clinical care for some, but not all, clients, and Title X and other flexible funding streams wrapping around that core to serve all clients and to provide them the full package of care they need (related article, Spring 2007, page 13). But this can put an increasing burden on providers, as they attempt to cobble together funding from a range of programs to meet clients' needs. Although the Medicaid expansions clearly free up resources under these other programs, it must be acknowledged that unlike Medicaid, funding under programs such as Title X is not open ended and the dollars often fail to keep pace with the rising costs of providing care.

Laying a Path

In the course of designing and implementing their Medicaid family planning expansions, state officials have built on and learned from earlier generations of Medicaid expansions. But they have also taken important next steps, by pioneering a range of techniques that either allow women to apply for and be enrolled during their visit or allow providers to be reimbursed for care delivered while a client's application is pending. The state officials have paved new ground in reaching out to high-risk populations and allocating other resources to pay for clients and services Medicaid will not cover. For their part, providers have become adept at leveraging both

Title X funds and other dollars to bridge remaining divides.

This experience, although clearly beneficial for family planning efforts, has relevance well beyond family planning. Many of the issues that policymakers have grappled with as they designed and implemented these expansions—reaching out to new populations, welcoming them into a strange system, meeting the range of clients' needs—are universal. In that way, the experiences and ingenuity of the family planning programs hold vital lessons as the Medicaid program continues to change and evolve. These lessons are especially important given the growing acceptance that Medicaid is likely to be a critical component of any serious discussion about broad-based health care reform (related article, Winter 2008, page 11).

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But for all the inventiveness of state policymakers in crafting the family planning expansions, and the clear impact these programs have had, their future remains precarious. As demonstration programs, they are approved by CMS for an initial five-year period only after a tortuous process that can easily last upwards of two years. Although the programs are clearly able to demonstrate at the end of that initial approval period that they have expanded access without increasing costs, they are nonetheless renewed only for a three-year term—hardly the kind of long-term stability needed for an effort on which millions of individuals rely for their health care. That long-term stability could be achieved by Congress moving to either allow states to expand Medicaid eligibility for family planning without having to first obtain a federal waiver, or even require them to do so. Such steps would give state policymakers and providers the kind of secure footing they need to continue the important innovation they have only just begun.

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