



State Government Innovation in the Design and Implementation of Medicaid Family Planning Expansions

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HIGHLIGHTS

- State-initiated Medicaid family planning expansion programs, established in 26 states as of March 2008, have learned from and improved upon earlier expansions for pregnant women and children to enhance program outreach, enrollment and service delivery.
- To expand outreach to clients, states have used tailored, community-based tactics, established informative program Web sites and contacted individuals receiving other forms of public assistance. To recruit a large network of providers, states have worked with professional organizations and associations, used targeted ads, e-mails and mailings, and developed Web sites for interactive orientation and training.
- Looking to streamline the enrollment process, states have automatically enrolled potential clients, such as postpartum women who are leaving Medicaid, and used existing databases to verify citizenship status and income. Most notably, they have pioneered innovative techniques to facilitate point-of-service application and enrollment.
- State expansions pay for a wide package of contraceptive and related services. Some states set aside their own funds for services and populations for which federal reimbursement is unavailable. States have also worked to ensure adequate provider reimbursement through regularly scheduled rate increases and targeted funding for client counseling and application assistance.
- To ensure client confidentiality, states have enrolled teens based on their own (rather than their parents') income and enrolled clients unable to use private insurance for fear of abuse. States have also moved away from issuing distinctive family planning identification cards or have eliminated the cards altogether.
- Family planning expansions have identified innovations that should serve future program design, both in the field of family planning specifically and for Medicaid and health care reform more broadly.



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Background

When Medicaid was first established in 1965, the low-income families covered by the program generally were headed by single mothers who received welfare cash assistance. In the 1980s, Congress broke the welfare-Medicaid link for low-income pregnant women by first allowing—and later requiring—states to extend eligibility for Medicaid-covered prenatal, delivery and postpartum care (including postpartum family planning services) to all women with incomes up to 133% of the federal poverty level—an income level far above most states’ regular Medicaid eligibility ceilings. At their option, states could expand eligibility for pregnancy-related services to women with incomes up to 185% of the poverty level or beyond.¹ In the 1990s, Congress continued this piecemeal, state-based expansion of public health coverage—most notably, by enacting the State Children’s Health Insurance Program (SCHIP) in 1997 as a companion program for Medicaid to provide coverage for low-income children.

Using as a model the expansions for pregnancy-related care, several states have moved to expand eligibility for Medicaid family planning services as well. Because these expansions limit the scope of coverage to family planning supplies and services and some related care, rather than the full package of services normally required under Medicaid, states seeking to adopt these programs 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. These waivers are limited both in scope (in this case, to family planning) and in time (to an initial five-year period), although states may apply for an extension; these extensions are generally given by CMS in three-year increments. Once approval of a family planning waiver is secured, the state may claim federal reimbursement for 90% of the costs of providing family planning services and supplies under the effort, just as it can generally for family planning services provided under Medicaid.

States can design waivers using different approaches, but the proposal must be “budget neutral” to the federal government over the five-year span of the effort; that is, the waiver cannot cost the federal government more than it would have spent in the absence of the waiver. States

that have obtained these waivers have argued that the cost of providing family planning services and supplies to individuals under the program pales in comparison to the cost of providing pregnancy-related services to beneficiaries who would otherwise become pregnant and eligible for Medicaid-funded pregnancy-related care.

To date, 26 states have obtained approval from CMS to expand the eligibility requirements for Medicaid family planning services (see figure, page 4). These expansions have taken one of three routes (see table, page 6).² The first built directly on the expansions for pregnancy-related care, under which states provide Medicaid-funded family planning services and supplies, as part of postpartum care, for 60 days after a woman gives birth. Under this provision, unless a woman qualifies for Medicaid under a different eligibility pathway, she would lose her Medicaid coverage after those 60 days. Four states currently have federal approval to continue coverage for family planning services for one or more years postpartum, an approach pioneered by Rhode Island and South Carolina in 1993.

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. These individuals might include, for example, young adults who were covered by Medicaid during childhood but no longer qualify because they are 19 or older, or parents whose household income has risen to a level above the typically low threshold for full Medicaid coverage.

The third—and boldest—approach taken by states has been to extend Medicaid family planning coverage based on income rather than on previous participation in the program. This approach raises the possibility of providing family planning services to residents who had not been previously covered under the program at all. Twenty states, beginning with Arkansas and South Carolina, have obtained federal permission to expand their income-eligibility levels for Medicaid-covered family planning services; most of these states have extended coverage to individuals with an income at or near 200% of the poverty level.

In general, when approving states’ applications for family planning waivers, CMS allows the programs to

more STI tests. More than half of the women served were tested for cervical cancer.⁴

Research on the impact of these efforts is accumulating. In various states, waiver programs have been found by state and federal evaluations and independent studies to:

- expand the number of family planning clients;
- improve geographic availability of services;
- broaden private physician participation in the provider network;
- increase use of effective contraceptive methods;
- extend the interval between pregnancies;
- help women avert unplanned pregnancies, unplanned births and abortions;
- reduce the number of teen pregnancies, births and abortions; and
- generate substantial savings for federal and state governments.

For example, after Rhode Island instituted a comprehensive expansion of its health care coverage, including extended family planning coverage for women following a Medicaid-funded birth, the proportion of women with Medicaid-funded deliveries who became pregnant within 18 months of a previous birth—a well-established risk factor for low birth weight and infant mortality—declined dramatically. Moreover, the disparity in birth intervals between Medicaid enrollees and privately insured women in the state was almost eliminated.⁶ Programs in Arkansas and South Carolina have reported similar findings.^{7,8} Because of the impact that family planning programs have had on extending intervals between pregnancies, the National Governors Association and the March of Dimes consider expanding Medicaid eligibility for family planning an important step that states can take to improve birth outcomes and reduce the incidence of high-risk births.^{9,10}

A national evaluation of Medicaid family planning waivers conducted by the CNA Corporation along with the schools of public health at Emory University and the University of Alabama at Birmingham, under a contract with CMS, has provided important evidence of the impact of the waivers.¹¹ The researchers found evidence that some of the programs expanded access to care, improved the geographic availability of services, increased the diversity of family planning providers and resulted in a measurable reduction in unintended pregnancy.

Moreover, Guttmacher Institute data from 2001 demonstrated that clinics in states with income-based expansions were better able than those in other states to meet the need for family planning services: Clinics in the expansion states served 50% of the women in need, while clinics in states without expansions served just 40%, and

only the expansion states had shown improvement in meeting this need between the mid-1990s and 2001.¹² More recently, a 2007 study by researchers from the Medical University of South Carolina found that Medicaid family planning expansions result in lower birthrates, and that broad, income-based programs have the greatest impact.¹³ Another study, released in 2007 by economists from the University of Maryland and Wellesley College, came to the same conclusion, finding a particularly pronounced impact on the birthrate among teens and among the low-income adults eligible for the waiver programs.¹⁴

Several studies have found that by providing contraceptive services to women and thereby helping them to avoid unintended pregnancies—care for which they would have been eligible for coverage under Medicaid—family planning waiver programs are highly cost effective. The CMS-funded national evaluation found that programs in all six states studied yielded significant savings to both the federal government and the states, including \$19 million in a single year in Alabama and \$30 million in Arkansas.¹¹

Family planning waivers have expanded access to care, improved the geographic availability of services, increased the diversity of providers and resulted in a measurable reduction in unintended pregnancy.

Similarly, evaluations of individual programs conducted by several states, as required by CMS as part of the federal waiver, have found that the savings that the programs generate by helping women avoid unintended pregnancies (and the Medicaid-funded deliveries that would otherwise follow) far outstrip the costs of providing family planning services to program enrollees.^{7,8,15} One study found that in 2002 alone, the California Family PACT program enabled 205,000 women, including 44,000 teenagers, to avoid an unintended pregnancy. By enabling women to avoid these pregnancies, the program averted 79,000 abortions, including 16,000 abortions to teens.¹⁶ Moreover, the evaluation showed the program to be extremely cost effective. The \$404 million spent under the program in 2002 generated a net savings of \$800 million within two years and \$1.8 billion within five years. Put another way, every dollar spent under the program saved \$2.76 within the first two years and \$5.33 within five years.¹⁷

Because several different approaches could be taken to expanding Medicaid eligibility, in 2006, Guttmacher Institute researchers projected the cost effectiveness of four scenarios for expanding eligibility for Medicaid-covered contraceptive services: establishing parity in all states between the eligibility requirements for contraceptive services and those for pregnancy-related care;

expanding eligibility nationwide to women with incomes up to either 200% or 250% of the poverty level; and giving each state the option to extend eligibility to women with an income up to 200% of the poverty level.¹⁸ In their projections, the researchers used data on enrollment in the existing waiver programs to estimate the impact if such programs were implemented in other states.

Under each of these scenarios, some women who would have been unable to access services at all would be able to obtain them, and some women who would have been using less-effective contraceptive methods would be able to use more-effective methods. Accordingly, all four of these expansion approaches would improve women's ability to avoid unplanned pregnancy and birth, as well as abortion.

Similarly, all of the expansion scenarios would result in significant cost savings to the federal and state gov-

ernments. The study found that the most cost-effective approach, however, would be to establish parity between the income ceiling a state uses to determine eligibility for Medicaid-funded pregnancy-related care and the state's income ceiling for family planning. Of the 20 states that have adopted an income-based expansion of family planning coverage, all but Minnesota and Virginia have taken this approach.

Although the impact would differ from state to state, nationally the 2006 research found that this approach would cost \$800 million but avert \$2.3 billion in costs from unplanned births—a net savings of \$1.5 billion in Medicaid costs annually by the third year of the program's operation. It would enable nearly 500,000 low-income women to avoid an unplanned pregnancy, reducing the number of

Characteristics of State Medicaid Family Planning Eligibility Expansions

| State | Basis for eligibility | | | Includes men | Limited to individuals aged ≥19 | Expiration date |
|----------------|----------------------------|--------------------------------|---|--------------|---------------------------------|-----------------|
| | Losing coverage postpartum | Losing coverage for any reason | Based solely on income (% of poverty level) | | | |
| Alabama | | | 133 | | X | 9/30/2008 |
| Arizona | X | | | | | 10/25/2009 |
| Arkansas | | | 200 | | | 1/31/2009 |
| California | | | 200 | X | | 3/31/2008 |
| Delaware | | X | | | | 12/21/2009 |
| Florida | | X | | | | 11/30/2009 |
| Illinois | | * | 200 | | X | 3/31/2009 |
| Iowa | * | | 200 | | | 1/31/2011 |
| Louisiana | | | 200 | | X | 7/1/2011 |
| Maryland | X | | | | | 5/31/2008 |
| Michigan | | | 185 | | X | 3/1/2011 |
| Minnesota | | | 200 | X | | 6/30/2011 |
| Mississippi | | | 185 | | | 9/30/2008 |
| Missouri | X | | | | | 9/30/2010 |
| New Mexico | | | 185 | | X (18+) | 9/30/2009 |
| New York | * | | 200 | X | | 9/30/2011 |
| North Carolina | | | 185 | X | X | 9/30/2010 |
| Oklahoma | | | 185 | X | X | 3/31/2010 |
| Oregon | | | 185 | X | | 10/31/2009 |
| Pennsylvania | | | 185 | | X (18+) | 6/1/2012 |
| Rhode Island | X | | | | | 7/31/2008 |
| South Carolina | | | 185 | | | 12/31/2010 |
| Texas | | | 185 | | X (18+) | 12/11/2011 |
| Virginia | * | | 133 | X | | 9/30/2010 |
| Washington | | | 200 | X | | 6/30/2009 |
| Wisconsin | | | 200 | | | 12/31/2010 |
| Total | 4 | 2 | 20 | 8 | 9 | |

*State also extends Medicaid eligibility for family planning services to these individuals. *Note:* As of March 1, 2008.
Source: Reference 2.

unplanned pregnancies nationwide by 15%. It would also prevent nearly 200,000 abortions, cutting the total number of abortions performed in the United States annually by 15%. Finally, 225,000 women would avoid an unplanned birth each year.

Meeting of State Officials

Although the impact of family planning expansion programs has been well documented, no studies have looked in detail at the implementation of these programs nationwide. That is a significant oversight: State and federal policymakers have made numerous decisions, large and small, that have shaped the various expansions and affected how they are perceived and utilized by family planning clients, health care providers and state officials.

To explore these critical implementation decisions and the innovations in program design and operation that have been achieved in several states, the Guttmacher Institute in November 2007 hosted an all-day working meeting in Washington, DC, with state officials responsible for imple-

menting income-based family planning waiver programs. Officials from 15 of 20 states with such programs participated in the meeting (Arkansas, Illinois, Iowa, Michigan, Mississippi, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, South Carolina, Texas, Virginia, Washington and Wisconsin). We followed up after the meeting with a series of telephone calls and e-mail exchanges to gather additional state-specific information. Representatives from four of the remaining five states (Alabama, California, Louisiana and Minnesota) were able to participate in that part of the process. New Mexico officials did not participate.

The meeting and these conversations focused on four areas of particular concern and innovation: outreach strategies, enrollment procedures, working with service providers and preserving client confidentiality. Unless otherwise given a reference, the information in this report—including information on states' implementation challenges and solutions and the context in which decisions were made—comes from the meeting and subsequent discussions.

Expanding Outreach Efforts

The Medicaid expansions for pregnant women that were introduced in the 1980s made great strides in changing the ethos of Medicaid, at least as applied to some women, into a program run with a conscious effort to reach out to new clients. As a consequence of this change in character, programs found the need to reach out to eligible, but nonenrolled, pregnant women. From the outset, the federal government reimbursed states for outreach activities, such as targeted mailings and the establishment of telephone hotlines, in an effort to increase prenatal coverage.¹ Creative program names have been used as a way to disassociate the program from the stigma often attached to welfare and Medicaid, and to convey broad eligibility to pregnant women across a state; these titles have included First Steps in Washington, Healthy Start in Massachusetts and Rite Start in Rhode Island.

Years later, SCHIP programs made use of similar outreach efforts to raise awareness and enrollment. Mass media campaigns were in most cases found to be less effective than targeted, culturally appropriate advertising aimed at particular populations. Community-based outreach allowed trusted members of the community to contact families, discuss details, answer questions and dispel misconceptions concerning expansion programs.¹⁹ SCHIP programs also adopted the tactic of creatively branding their programs, with names such as PeachCare for Kids (Georgia) and All Kids (Illinois).

Outreach to Clients

Family planning waiver programs have built upon this foundation by making use of these proven tactics. In the process, they have developed important innovations of their own.

Broad-Based Outreach

Branding is seen as a key component of most states' initial outreach efforts. Each state's decision about how to label its family planning expansion program depends in part on attitudes about the broader Medicaid program in the state (see box). Many states chose distinctive names for their family planning program in an effort to help potential clients distinguish those programs from Medicaid and

to indicate that their programs accept women who would not otherwise be eligible for public assistance programs. Other states, such as Oklahoma and Wisconsin, have branded their programs to make clear that the programs are part of a broader family of similarly named Medicaid and SCHIP programs in the state.

States typically make use of broad outreach techniques (see box) when they first introduce a family planning waiver program. In most cases, mass media campaigns (involving radio, TV and newspaper ads) improve knowledge of the program, but prove too costly to maintain over the life of a waiver. One exception is in Alabama, where the government runs a statewide television commercial for its waiver program, Plan First, every year for four weeks during primetime. Alabama officials

EXPANSION PROGRAM NAMES

Alabama: Plan First
Arkansas: Women's Health Waiver
California: The Family PACT Program
Illinois: Illinois Healthy Women
Iowa: Iowa Family Planning Network
Louisiana: Take Charge
Michigan: Plan First!
Minnesota: Minnesota Family Planning Program
Mississippi: Care for Yourself
New York: Family Planning Benefit Program
North Carolina: Be Smart
Oklahoma: SoonerPlan
Oregon: Family Planning Expansion Program (FPEP)
Pennsylvania: SelectPlan for Women
South Carolina: Family Planning Waiver Program
Texas: Women's Health Program
Virginia: Plan First
Washington: Take Charge
Wisconsin: BadgerCare Plus Family Planning Services

noted that although the airtime is expensive, the state has saved considerable money by expressly designing a commercial that could be aired every year without losing its effectiveness, regardless of changes that had been made to the program. The commercial has had, and continues to have, a noticeable impact on the number of monthly inquiries to the program's telephone hotline—at first, the number of calls tripled in the month following the ad's airing, and several years later, the number still more than doubles when the ad is shown.

Postpartum women who are leaving Medicaid may have particular need for family planning services, and most family planning expansions reach out to these women via mailings and phone calls.

After an initial broad outreach campaign, programs typically scale down their mass outreach and rely on their Web sites and on occasional regional ad blitzes to build recognition. Texas relies heavily on targeted outreach programs, but it is in the process of planning a regional ad blitz involving transit ads and will be documenting the impact of the campaign on enrollment. Depending on the results, similar ad campaigns may be rolled out in the future.

Program Web sites can be a fount of information, when designed in a user-friendly way. California's client Web site, for example, includes fact sheets on emergency contraception in 11 different languages, including Armenian, Farsi, Hmong and Tagalog. Illinois' Web site provides users with many options, such as the ability to download an application, learn about covered services and see a picture of what their enrollment card will look like (so they know what to look for in the mail). Several states, including California, Illinois, Louisiana and Virginia, now include e-mail links on their Web sites that allow users to provide instant feedback on the layout of the site and ask questions about the program. And almost all states include tools, such as provider maps and zip code locator tools, that help users to find providers in their area.

Outreach via Other Public Programs

As programs segue toward more focused outreach, efforts are often directed toward high-risk men and women likely to make use of family planning. Postpartum women who are leaving Medicaid may have particular need for family planning services, and most family planning expansions reach out to these women via mailings and phone calls. For example, beginning in 2008, North Carolina is sending postcards to women twice during their pregnancy to let them know that the family planning program will be available to them after they give birth, and to help them understand the limits of the program's coverage. Virginia's

recently expanded program will send a letter one month before a woman's due date detailing the services available through the state waiver program.

Several states are making concerted efforts to reach potential family planning clients who may be 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 state's Plan First program in the packets of information sent out at the beginning of each school year to parents of children enrolled in Head Start. Pennsylvania's program, which began in early 2008, will be checking state databases for women who have been enrolled in any of the agency's other income-based programs, including food stamps, welfare and the school lunch program. The waiver program will also offer family planning services to those individuals who have been wait-listed for the state's more comprehensive medical program.

Targeted Outreach

More challenging to states is outreach to individuals at high risk for unplanned pregnancy who may be eligible for the family planning expansion but are not already receiving any state benefits. University students, for example, may be sexually active but inexperienced in practicing contraception. In several states, including Minnesota and Oklahoma, programs work directly with college and university health clinics and health fairs in an effort to reach out to

STRATEGIES FOR OUTREACH

- Program names chosen to emphasize wide-spread eligibility
- Mass media campaigns (e.g., print, radio or TV advertising)
- Regional advertising (e.g., mass mailings and billboards)
- Central Web site and telephone hotline
- Outreach to postpartum women and to recipients of other public programs
- Targeted outreach to high-risk groups
- Culturally and linguistically tailored outreach materials
- Community-based outreach workers and local partners
- Outreach at community centers and events
- Provider recruitment (e.g., bulletins, Web portals, provider associations)
- Provider training (e.g., in-person, video conferencing and "webinars")

students. Because adolescents are another vulnerable group that may be sexually active but unaware of family planning, New York maintains the Growing Up Healthy Hotline, which serves adolescents as well as others seeking health information. In addition to family planning, the hotline includes information on lead poisoning, prenatal screening, asthma, tuberculosis and much more.

Many states make a special effort to reach out to Latina women, because of their relatively high rates of unintended pregnancy, relatively low rates of private insurance coverage and potential language barriers. Ideally, the outreach materials are designed expressly to appeal to Latina women. To increase awareness among Latina women, Texas has produced bilingual outreach materials for potential enrollees and will be testing Spanish-language transit ads in their upcoming regional ad campaign.

Outreach personnel in Alabama contact women receiving food stamps or WIC, and they provide information on the state's Plan First program to parents of children enrolled in Head Start.

One particularly promising tactic has been the use of local outreach teams to assess the needs of and reach out to vulnerable members of their own community. The Oklahoma program's interagency working committee on outreach, for example, talks with patients and providers to construct outreach messages and help improve the effectiveness of the program's marketing strategies. In some cases, these outreach teams work on behalf of a broad range of state programs, including Medicaid and SCHIP. In Texas, for example, the state works with community-based organizations, such as local Community Action Agencies, to conduct grassroots outreach at health fairs and back-to-school events and to help people fill out and submit applications for Medicaid, SCHIP and the family planning waiver program. The program created outreach materials that mention natural family planning so that religious organizations, such as Catholic Charities, will include the waiver program in their greater community-based outreach. Within the Latina community, the Texas Health and Human Services Commission has provided training to *promotoras*—health advocates who raise awareness of health and educational issues—to talk to women about the waiver program one-on-one, in small groups or at community meetings.

Other outreach workers focus specifically on the state's family planning efforts, including not only the new waiver program, but also the existing family planning clinic system. As part of Alabama's outreach effort, for example, social workers and nurses—at least one of whom is based in every county health department in the state—conduct

psychosocial assessments for family planning clients and also go out into the community to visit physicians' offices, colleges and other locations to increase awareness of the program. Enrollment mapping techniques reveal where enrollment and awareness of the program may be low, allowing these outreach workers to better direct their

Many states make a special effort to reach out to Latinas, because of their relatively high rates of unintended pregnancy, low rates of private insurance coverage and potential language barriers.

efforts. In Louisiana, state outreach staff contact potential clients at parish hospitals and clinics, physicians' offices, pharmacies, colleges, churches, large companies, and state fairs and other major events. These staff members educate clients about the availability of state assistance through the family planning program as well as other state benefit programs. By making repeated trips to many locations, building relationships with local staff and regularly supplying them with brochures and other materials, the coordinators' outreach efforts continue even when they are elsewhere.

These broad, statewide efforts are sometimes funded through the waiver itself, or may instead draw on another source of state funding. In other cases, outreach efforts are directed and funded by local family planning providers—often using Title X funds—rather than the state's expansion program. For example, the Venice Family Clinic in Los Angeles sends outreach teams to street corners and homeless shelters with backpacks of condoms and basic educational materials. Clinic personnel report that it often requires multiple visits and conversations to make people feel safe enough to come in for services. Similarly, to provide Latina parents with information about parent-child communication, STIs, contraceptive methods and the services available at clinics, Planned Parenthood of Wisconsin conducts home health parties, an approach based on the observation that many people are especially comfortable talking around a kitchen table.²⁰

Outreach to Providers

Service providers interact with potential family planning clients on a daily basis and can be instrumental in boosting waiver program enrollment. Clinics and doctors' offices can hand out informational brochures and integrate family planning programs into their existing community outreach materials.

An equally important reason to recruit providers willing to participate in a family planning expansion is to improve the geographical diversity of providers, so as to ensure that services are conveniently accessible throughout the

state to any potential client. The CMS-funded national evaluation found that waiver programs have succeeded on this front: Geographic access increased in all six states studied.¹¹

Recruitment

Some state programs rely heavily on an existing network of clinics and private physicians who already accept Medicaid patients and/or receive specific grants—from Title X or other sources—to provide family planning services. In many states, in fact, Medicaid providers automatically become eligible to serve family planning waiver clients, and billing and enrollment procedures are integrated seamlessly into the state's larger Medicaid program; as a result, providers require little training to take part in the waiver program. Other states, however, must reach out to enroll providers individually, because their program is run separately from broader Medicaid or demands special services (such as enrollment assistance) or procedures (such as specialized billing) on the part of the provider.

Regardless of whether providers are automatically eligible to provide services under a waiver program or are actively enrolled, they need to learn initially about the program and its limitations, and they need refresher information and updates on a periodic basis. Most states make use of bulletins (by mail or e-mail) and post considerable amounts of information on their Web sites. When Michigan was preparing to introduce its waiver program, it made use of multiple channels of contact to increase provider knowledge of the program. Officials sent out bulletins to providers twice in the months leading up to the program's debut, as well as e-mail messages to providers and office staff. Community health centers and health departments, in particular, were kept in the loop throughout the waiver approval process. The state also worked with several provider associations, such as the Michigan State Medical Society and the Michigan Primary Care Association; it provided them with a two-page summary of the program that some of the organizations included in their monthly newsletters, and made presentations at the groups' regular meetings. Similarly, Illinois has also worked with provider organizations, such as the Illinois Public Health Association and the Illinois Maternal and Child Health Coalition, to send out notices to their members in an effort to boost provider involvement.

When New York first implemented its waiver program, the state took a unique approach to boosting provider knowledge and participation. It organized a two-part, noontime radio broadcast that aired statewide and was targeted to Medicaid providers of family planning services throughout the state. A regional television personality moderated a discussion among several experts about

the importance of the program and how it operated (for instance, how providers could become qualified to help enroll clients). The experts also fielded questions submitted by listeners by phone and fax. The state worked with many stakeholders, such as the local chapter of the American College of Obstetricians and Gynecologists, to organize the broadcast and inform providers about it beforehand. The state has also made use of local outreach staff, who are employed by nonprofit family planning agencies and funded by the state's family planning program. The outreach coordinators explain the waiver program to Title X providers, present information to providers from outside the state's Title X network, do ad hoc training and program updates when needed and give feedback to the state about implementation issues.

Increasingly, states have turned to the Internet, allowing providers to download videos of earlier training sessions (along with print resources) or to participate in live 'webinars.'

Clients who live near the border of their state will sometimes receive services from a provider in a neighboring state. Most states allow out-of-state providers (often within a specific distance of the border) to act as Medicaid providers for state residents, and a few have actively recruited them. For example, when Washington first rolled out its family planning waiver program, officials were concerned about access to care, especially in rural communities. In response, they recruited new providers—specifically for the family planning expansion—from the neighboring states of Idaho and Oregon (but not across the border into Canada). Now family planning providers are distributed throughout the state in keeping with the population pattern and density. Similarly, Oklahoma recruited providers—for both its waiver program, SoonerPlan, and its broader Medicaid effort, SoonerCare—in its neighboring states (including Arkansas, Kansas, Missouri and Texas), and Mississippi is hoping to increase coverage in all four of its border states.

Training

Provider training is one particularly vital part of outreach. Supplying some sort of training to new providers—either for Medicaid generally or a family planning waiver program specifically—is a standard way to promote efficient and accurate billing, and to educate providers about what services are covered and about the rights and obligations of the providers and their patients. Training is also necessary when new program rules are initiated that affect every participating provider, such as the new requirement that

Medicaid enrollees provide documentation of their citizenship and identity imposed by the Deficit Reduction Act of 2005.

Many states make a concerted push to train providers before the launch of their waiver program, typically hosting statewide or regional gatherings, sometimes with video conferencing links to other sites. For providers that join an established program, states may provide training through periodic catch-up gatherings or one-on-one site visits. For instance, California's Family PACT program has several features that are different from those of the state's general Medicaid program, known as Medi-Cal. To help new providers or existing providers with recent staff turnover, the program runs monthly, one-day orientation sessions across the state. In addition, the state hosts regional forums to bring together providers from a specific area to receive program updates and "special interest" training sessions to address issues such as best outreach practices, adolescent reproductive health needs and new

contraceptive methods. Similarly, Michigan held video conference sessions around the state for providers when its application first went live online.

Increasingly, states have turned to the Internet, allowing providers to download videos of earlier training sessions (along with print resources) or to participate in live "webinars." Oregon, in fact, purchased headsets with microphones to help clinics participate in their online training sessions. North Carolina posted its training bulletin online through its Web site's provider portal. The provider bulletin includes lists of covered drugs and services, examples of how to fill out important forms (such as patient consent forms and referrals) and lists of billing codes. Pennsylvania is developing an online training module on its Web site for certain providers who use its online tool to help enroll potential family planning clients. Virginia, too, has an online portal for providers, with access to billing codes, lists of covered services and order forms for family planning documents.

Streamlining the Enrollment Process

As one of the major hurdles to growing any expansion program's client base, enrollment practices have been the focus of many innovations over the past several decades. The pregnancy-care expansions of the 1980s took critical first steps in streamlining the eligibility process. In order to attract as many pregnant women as possible, enrollment procedures for pregnant women were adjusted to allow for quick processing in neutral settings. Simplified asset tests allowed for a shorter, easier application process that could be completed by mail without a cumbersome (and potentially humiliating) in-person interview. At the same time, application forms were made available at sites not associated with welfare, such as health clinics and hospitals.¹

SCHIP programs have aimed to further reduce the length of applications for eligible children.²¹ Enrollment has been simplified through the use of universal applications for a range of government programs and through expedited, "express lane" enrollment for families that have established their income through programs with similar eligibility requirements (such as WIC or the school lunch program). Allowing clients to self-declare their income without providing verifying documents—but often with after-the-fact checks via government databases—has

allowed states to remove barriers to enrollment while maintaining program integrity.^{22,23}

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. The pregnancy-care expansions pioneered two enrollment tactics: outstationing and presumptive eligibility. Under outstationing, Medicaid eligibility workers are placed at health care delivery sites to begin processing a client's application while allowing her to immediately receive government-reimbursed services. Presumptive eligibility allows health care providers, rather than government workers, to certify a client as eligible for temporary Medicaid coverage so that she can obtain prenatal care at her first visit; she then has to apply and be approved for actual Medicaid coverage through the regular procedures in use in that state. SCHIP programs have learned from these experiences, and many states allow for presumptive eligibility in an effort to provide services at first contact.²⁵

Family planning expansion programs have built on these innovations and carried them a step further (see box).

Auto-Enrollment

Family planning expansion programs in many states have succeeded in eliminating the application process entirely for certain groups of enrollees. The most common example of this tactic is when states automatically enroll into their family planning waiver program any woman who is otherwise losing Medicaid coverage after giving birth. Typically, a woman will receive a letter in the mail or a phone call from her provider letting her know that she has been automatically enrolled in the program. This is often accompanied by a new Medicaid or family planning client card and information on participating clinics, available services and how to contact the program if the woman has questions.

Although this tactic ensures high enrollment into the family planning program, follow-up efforts in several states have found that most auto-enrolled women do not make use of their new coverage. When polled, many do not know or remember that they have been enrolled, or they do not understand what benefits are (and are not)

STRATEGIES FOR ENROLLMENT

- Automatic enrollment of clients losing broader Medicaid coverage
- Simplified application forms
- Applications submitted remotely and without requiring in-person interview
- Databases to confirm citizenship status, identity and income
- Enrollment in other income-based programs used to verify eligibility
- Joint application with, or screening for, eligibility in other public programs
- Outstationing and presumptive eligibility
- Point-of-service enrollment
- State funding of initial visit
- Retroactive payment to providers

available to them. For this reason, some states have moved to repeatedly remind pregnant or postpartum women that they have been, or are about to be, enrolled in a family planning program, or to offer the women an opportunity to decline coverage. In Illinois, for example, family case managers are informed when a woman has been auto-enrolled for family planning coverage, so that the case manager can help her understand the program and find a family planning provider. In Arkansas, all women enrolled in Medicaid because of a pregnancy are asked before they give birth whether they would like to be moved into the family planning program postpartum (effectively, an “opt in” approach).

Individuals in Illinois who lose Medicaid coverage are automatically mailed a card providing them with three months of family planning coverage, along with an enrollment form to continue coverage after that.

Illinois takes the concept of auto-enrollment further. Its initial waiver program, approved in 2003, was limited to individuals losing full-fledged Medicaid coverage for any reason—including not only postpartum women, but also young adults who had aged out of their childhood coverage, and families whose earnings had risen above the Medicaid income ceiling. When the state’s waiver was revised in 2006 to extend eligibility to individuals solely on the basis of income, the state held on to its earlier enrollment process as well. Individuals who lose Medicaid coverage are automatically mailed a card providing them with three months of family planning coverage, along with an enrollment form to continue coverage after that.

There are several other examples of systems that automatically screen individuals without necessarily enrolling them. Under Michigan’s new electronic application system for Medicaid and SCHIP, if a woman signs up her child for Medicaid, the system will automatically determine whether she is eligible for the state’s family planning program and will give her the opportunity to enroll. Pennsylvania utilizes a similar screening system: When individuals apply for public programs online, the system determines whether they are also eligible for the state’s family planning program. They may decline to participate if they do not want family planning coverage, are pregnant or have been sterilized.

States have also considered the idea of automatically moving 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. Women who become pregnant while receiving family planning services in Alabama, Iowa, Louisiana and New Mexico are auto-

matically enrolled in the state’s Medicaid pregnancy-care program.²⁴

Simplified Applications

In attempting to streamline enrollment, and having learned from experience (and in some cases, from surveys of potential clients) that long, complicated applications will severely depress enrollment, some states use one-page applications that can be filled out quickly. These applications generally ask for a limited amount of information, including:

- contact information;
- age and gender;
- whether the client is sterile or pregnant;
- insurance and citizenship status;
- social security number; and
- family size and income.

This is much simpler than many Medicaid applications, which may require detailed information about a family’s assets, income and financial obligations. In many cases, shortened applications are simple enough that potential enrollees can fill them out on their own. To take advantage of this simplicity and make the process more convenient, most states allow applicants to start or complete an application remotely by mail, fax, telephone or the Internet, and few states actually require in-person interviews to enroll in a family planning program.

The recently imposed requirement to document citizenship and identity, however, has interfered with this process, because it requires a state employee or clinic staff member to view original documents, rather than copies. Few applicants are willing to mail in their actual driver’s license or passport, and states do not wish to take responsibility for such documents. To mitigate this problem, states are permitted to use government databases to confirm enrollees’ citizenship status and identity, and most do so (for the family planning expansions and for Medicaid more broadly). This tactic is, for the most part, possible only for individuals born in the given state. Nevertheless, Pennsylvania has taken it upon itself to help all of its Medicaid clients obtain citizenship documentation, even if it requires obtaining out-of-state documents. Minnesota does the same and is participating in a pilot program attempting to link vital records across multiple states.

States have also made use of databases to ease the burden of verifying an applicant’s income. Some states maintain records of proof of income or citizenship that the individual provided during a separate application process. Still others use privately run databases (e.g., The Work

Number) designed to help both government agencies and private companies verify employee incomes. Several states have adopted another approach, pioneered by SCHIP, that allows clients to self-declare their income; the states usually verify the information after the fact by a database check.

In Texas, women applying for the family planning waiver program do not have to demonstrate proof of their income, if they did so recently to receive welfare cash assistance, food stamps or WIC.

At least one family planning program makes use of something similar to the SCHIP concept of “express lane” enrollment. In Texas, the state refers to it as “adjunctive eligibility”: Women applying for coverage in the family planning waiver program do not have to demonstrate proof of their income a second time, if they did so recently to receive welfare cash assistance, food stamps or WIC. Each of those programs has an income eligibility ceiling at or below that of the family planning expansion. Women still need to provide documentation of identity and citizenship when they apply for family planning coverage, since the other welfare programs do not require that documentation. For this reason, adjunctive eligibility may be most helpful, instead, in streamlining the renewal process. The state will first check to see if a woman’s income has been verified through another program; if so, the renewal application will ask only whether the woman is pregnant or sterilized, or has private insurance. (A positive answer to any of those questions would mean she is no longer eligible for the family planning waiver program.)

Screening for Other Public Benefits

Family planning programs, like the pregnancy-care expansions before them, struggle to strike an appropriate balance between simplicity and thoroughness during the application process. Program administrators want to enroll and provide services to clients as quickly as possible, while also ensuring that these clients are enrolled in the most comprehensive program available to them. Striking a balance between these priorities is often difficult, but states are working to find innovative ways to achieve such a compromise.

In almost every state—even those placing a strong emphasis on simplicity—efforts are made to educate applicants about their potential eligibility for programs with a more robust package of services (such as full Medicaid). Some states go further and screen all applicants for potential eligibility in other programs, and either send these ap-

plicants the proper enrollment forms or offer such choices in person.

Knowledge about other programs can be particularly problematic for women and men who are applying for coverage from home. Yet, online application systems have the potential to marry convenience with thoroughness, guiding applicants through the process and helping them to choose among the public programs for which they might be eligible.

Wisconsin’s online application system, for example, allows an individual or family to be screened simultaneously for eligibility in a wide variety of programs, including not only family planning and other health care coverage, but also programs for long-term care, for subsidizing food and energy expenses, and for receiving state and federal tax credits. They can then apply for several of the programs, including family planning, through the same Web site and check on the status of their benefits. Pennsylvania’s online system works in a similar manner, and allows a community-based organization or health care provider to assist with the application and screening process and to keep tabs on the application.

Wisconsin’s online application system allows an individual or family to be screened simultaneously for eligibility in a wide variety of programs.

Oklahoma is in the process of designing a particularly ambitious online application and enrollment system, funded by a special transformation grant from CMS. The state anticipates that the new system will make applications easier, quicker and more convenient (available 24 hours a day, seven days a week), while educating state residents about the diverse programs offered by the state. It also expects the system to make it easier for residents to move back and forth between programs as their eligibility changes. One innovation will be the use of dedicated computer kiosks to ensure access for people without Internet access and, by their placement in the community, to serve as an additional method of outreach.

Point-of-Service Application

Despite the many options available, state officials report that most clients choose to apply in person at a social services location or at a provider’s office. In-person application allows clients to consult a knowledgeable staff member while completing the forms and to submit important verification documents at the time of application.

The application process is particularly effective and convenient if done at the point-of-service. This approach allows applicants to obtain family planning services and

supplies immediately, without having to wait for their applications to be processed and without having to make a second visit. A client may leave the provider's office fully enrolled, presumptively enrolled or with a pending application. What matters most is that the client leaves having obtained family planning services, and knowing that his or her application is approved or in the process of being approved and that the provider is reimbursed for these services.

Outstationing and Presumptive Eligibility

A few states greatly expedite the application process in order to allow clients to enroll in the program at the point of service and to become eligible to receive family planning services in one visit. Of the various tactics available, one that family planning expansions do not commonly use is outstationing (i.e., Medicaid eligibility workers placed at health care delivery sites). The only exception is in Louisiana, where dedicated state employees conduct family planning outreach away from government offices through the use of laptop computers with wireless Internet connections. These outreach personnel enroll clients at public health clinics across the state operated by the Department of Health and Hospitals. If a woman is interested in applying for the family planning program, the outreach workers can enter her information into the system, check to see if she is eligible and enroll her on the spot. Because the state's data systems are linked together, the outreach staff can ascertain whether a given woman is already enrolled in the family planning program (and has forgotten) or in full-fledged Medicaid or SCHIP. They can also determine whether her income and citizenship have been confirmed through enrollment in another state program. If not, they can use state and private databases to verify her income and (if she was born in state) her birth certificate; in many cases, the only documentation she needs on hand is her driver's license.

Presumptive eligibility—allowing health care providers, rather than government workers, to certify a client as eligible for temporary Medicaid coverage—is another approach that few family planning expansions use. Presumptive eligibility had been an important part of the family planning programs in several states, notably Minnesota and, until this year, Wisconsin. However, CMS appears to have decided to phase out the practice from the family planning programs.

Point-of-Service Enrollment

Instead of using outstationing or presumptive eligibility, three states' family planning waiver programs have pioneered an innovative mechanism 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 (the first out of the gate), Iowa and Oregon all have some variation of this same-day, point-of-service enrollment.²⁵

Significantly, clinic staff do not make the actual eligibility determination. Rather, specially trained clinic personnel walk a client through the program application, verify whatever documentation is required and enter the client's information into the state's computer system. During the client's visit, the state's computer system is able to determine whether the client is eligible and issue a notice of decision.

California, Iowa and Oregon allow clients to sign up for family planning coverage at the point of service, receive services and leave their provider's office officially enrolled in the program.

In California, the client actually leaves with an enrollment card in hand, along with a method of contraception. In Iowa, the card is generated centrally and mailed to the client's designated mailing address. Oregon does not issue enrollment cards.

State Funding of the Initial Visit

In another type of effort to provide services at the time of application, three states have implemented funding strategies meant to guarantee the provision of services before the client's application is finalized. This is particularly useful in cases where the new citizenship documentation requirement has made it difficult to immediately confirm a client's eligibility. In Oregon, the only clients not enrolled at the time of their initial clinic visit through the above-mentioned point-of-service function are those for whom enrollment is delayed by the need to document citizenship. To address this problem, the legislature has appropriated funding to pay for a one-time visit for such clients. By tracking the names of these clients in a database, the state ensures that a client can receive only a single such visit in her lifetime.

Pennsylvania will be taking a similar approach for clients enrolled by one of the state's "community partners." These are organizations—such as health care providers and community centers—that have been certified by the state to help a woman enroll in a state program, such as the family planning waiver program, using the state's online application system. The state has been using the concept of community partners for a variety of welfare-related programs, but the concept is being vastly ex-

panded by signing up family planning clinics as partners, and state officials report that the number of participating sites had already tripled as they geared up for the waiver program's debut in February 2008. If a community partner helps a client to sign up and the client's application is eventually approved, the provider will be reimbursed via the waiver program. If, however, the applicant later proves to be ineligible (for instance, because her income is above the ceiling), the state will pay for the visit out of a special fund. The only exception would be if a community partner attempts to sign up a person who is obviously ineligible (e.g., a man or someone who is pregnant, too young or too old). A community partner will be able to check on the case status of clients they help enroll, and will be notified when the client is finally declared eligible (so providers will know when to file for reimbursement).

Until the beginning of 2008, Wisconsin, with the support of the federal government, utilized presumptive eligibility as a means to provide same-day services to applicants while assuring that providers would be reimbursed for their services, even if the application was ultimately rejected. Under the recently renewed waiver, federal funding is no longer available if the woman is not subsequently enrolled in the expansion program. For clients who end up enrolled in the program, the services provided are reimbursed with federal and state dollars, as usual. For clients who are deemed ineligible, however, the state, at least for now, is providing reimbursement using general purpose state revenue.

Leveraging the Provider Network

The above tactics are beneficial for family planning providers as well as clients. By the time a client leaves the office, the provider knows that reimbursement is guaranteed—either because the client is already enrolled in the waiver program or because dedicated state funds will cover a client whose application is rejected. This guarantee acts as an important incentive for providers to serve and help enroll family planning clients. This is particularly true for private physicians, who do not have Title X or other grant funds to cover the cost of services for individuals found to be ineligible for the Medicaid expansion.

Even in the absence of one of the mechanisms described above, however, most family planning expansion programs are still able to rely on government or nonprofit

clinics to sign up many of the program's participants.

Title X clinics and federally qualified health centers provide services to and enroll the great majority of family planning waiver program clients. Their familiarity with these waiver programs allows them to identify a qualified applicant with great accuracy, so that their financial risk is small. In addition, the existence of generalized funds (through Title X or state monies) allows them to take on this measure of risk when providing services to applicants. If the client is ultimately enrolled, most states reimburse delivered services back to the first day of the month of application. In this way, providers may assist in the application process, deliver family planning services and be reimbursed once the application is approved at a later date. Clients who are rejected may be forced to pay a small amount for services based on a sliding scale; Title X or other clinic funds are used to make up the difference. State waiver program officials report that clients are informed that they may be charged for the services delivered if they are rejected by the waiver program, and this serves as an incentive for the client to complete his or her application.

Oregon, Pennsylvania and Wisconsin have implemented funding strategies meant to guarantee the provision of services before the client's application is finalized.

In Arkansas, as but one example, county health departments and other clinics are certified by the state to accept applications and then fax them to the central program office for determination of eligibility. Although it can take up to 45 days for that determination to be completed, the application is simple enough that clinic staff can usually tell at the point of service that the application will be approved. Providers who feel confident in their ability to spot an eligible applicant and have general funds to fall back on will often at the time of application provide services for which they expect to be reimbursed at a later date. Similarly, in Oklahoma, providers may assist in the application process and be reimbursed back to the first of the month for services provided to an applicant who is approved for the waiver program. Oklahoma processes applications quickly and with few rejections, so most providers know they will be reimbursed for services provided to applicants.

Partnering with Providers to Ensure Access to Care

Every Medicaid expansion program has relied on the support and cooperation of the provider community and has had to create incentives for providers not only to participate, but to make available the broadest possible package of services. Pregnancy-care programs have worked with providers to offer an enhanced package of care to low-income pregnant women. Medicaid-covered services include case management, psychosocial risk assessment, nutrition counseling and, in some cases, home visitation and transportation services. In many states, reimbursement rates to providers are enhanced in an effort to increase participation in the program and improve provider diversity.¹

Similarly, as states have implemented SCHIP, they have found that proving eligibility has been a major barrier to enrollment; in response, they have added enrollment assistance to the package of services they fund under SCHIP, paying for schools and other venues to assist in the enrollment process.²⁵

Family planning waiver programs, too, have used a variety of approaches to ensure that their providers offer a wide variety of services and assistance to program clients (see box). In doing so, they rely heavily on the standard of care for publicly funded family planning services established by the Title X national family planning program.

Services and People Covered

All of the waiver programs—like Title X and broader Medicaid—pay for a wide range of contraceptive choices to ensure that a client is able to choose a method that best fits her or his health and lifestyle needs. The pro-

grams also pay for the contraceptive counseling that is necessary to help a client choose among those methods and learn to practice contraception effectively.

Sixteen of the 20 income-based expansion programs are paying for coverage of emergency contraception.²⁶ With one exception, the expansions follow the practice of the state's broader Medicaid program. (In Texas, emergency contraception was excluded from the waiver program, but not broader Medicaid, in the legislation that directed the state to apply for a waiver.) However, the behind-the-counter status of emergency contraception for adult women has led to some complications, as Medicaid reimbursement typically requires a prescription, even for a drug that can be dispensed without one. Illinois' Medicaid program has overcome this potential problem by having a pharmacy check the state's data system to confirm a woman's eligibility, obtain her signature and then bill Medicaid using special codes in place of the prescriber name and identification number that are normally required.

Waiver programs also support Title X's standard of care by covering many other services generally provided at a family planning visit, such as a comprehensive physical examination, education and counseling, routine blood work, and testing for pregnancy, cervical cancer and STIs. Unfortunately, some other standard services are inconsistently covered under waiver programs—particularly, treatment for problems discovered during a family planning visit.

Coverage of STI treatment, especially, varies considerably across family planning waiver programs: Some waiver programs do not pay for treatment of any STIs, while others pay for a wide range. South Carolina, for example, now pays for treatment of six STIs (chlamydia, herpes, gonorrhea, syphilis, trichomoniasis and yeast infection), if detected during the course of an initial or follow-up family planning visit. (Five of the six can be cured; herpes is not curable, but antiviral drugs help suppress outbreaks and reduce transmission to partners.) One impetus for covering these services, according to state officials, is that untreated STIs can hinder the effective use of birth control. Another is that although other state and federal programs are available to provide STI treatment, funding is limited, and in many cases a client would have to be treated at a different location. A few states have set aside funds

STRATEGIES FOR PARTNERING WITH PROVIDERS

- Broad package of contraceptive and closely related services
- State funding for STI treatment services
- State funding for ineligible individuals
- Regularly scheduled reimbursement rate adjustments
- Cost-based reimbursement
- Enhanced reimbursement for counseling and application assistance

specifically for the treatment of STIs when these services are not included in the waiver package, as well as to cover treatment for a client's sexual partners.

However, most programs do not provide treatment for other conditions discovered during a family planning visit. Women found to be pregnant, of course, may be moved over to Medicaid coverage for pregnancy-related care. Coverage of services to follow up on an abnormal Pap test may be more problematic, because treatment of cervical cancer is beyond the scope of the family planning waiver programs. In some cases, family planning clients may be able to receive government-funded treatment under another Medicaid expansion, authorized under the Breast and Cervical Cancer Prevention and Treatment Act of 2000.

A few states have also dedicated their own money—without any federal reimbursement—to pay for family planning coverage for women deemed ineligible for the waiver program. California uses state funds to cover the cost for state residents whose care is not eligible for federal reimbursement, and Washington uses state funds to pay for 10 months of additional postpartum family planning for noncitizens ineligible for the Take Charge program.

In the absence of dedicated funds, providing services for ineligible noncitizens falls to the nation's safety-net providers, stretching further their already scarce dollars. Community health centers, Title X-supported clinics and similar agencies cannot turn away a patient because of immigration status. Some state officials and advocates stress that because Medicaid must pay for delivery services regardless of immigration status, as well as for medical care for the infant (who will be a U.S. citizen), providing family planning services to recent and undocumented immigrants is ultimately cost effective.²⁷

A few states have dedicated their own money—without any federal reimbursement—to pay for family planning coverage for women deemed ineligible for the waiver program.

Over the past several years, CMS has been phasing in a new rule prohibiting state waiver programs from covering individuals with "creditable" private insurance coverage. Interpretation of this rule has varied across states, and in many cases it has threatened the provision of family planning services to women whose insurance does not pay for the full range of such services. One state, Illinois, has decided to spend its own money to overcome this limitation. The state has set up its billing system to flag clients who, on their application, reported that they have

private insurance coverage for birth control. The state will then pay the provider for those services, attempt to obtain reimbursement from the insurance company and, failing that, pay for the services entirely with state dollars. (The state also pays 100% of the costs for mammography and folic acid supplementation—services rejected by CMS for federal match under the waiver.) The system is completely transparent to the client.

Reimbursement Rates

The overall Medicaid program is most states' largest single expense, and one that has been growing significantly faster than state revenues. As a result, many states have taken measures to maximize their control over Medicaid costs. Generally, states have little control over the demand for Medicaid services: Once a state sets its eligibility criteria, it cannot limit the number of people who enroll in the program and must instead accept everyone who is eligible. Thus, to control costs, states must focus on the supply side of the equation, and many have chosen to maintain firm control over the reimbursement rates offered to providers.

Reimbursement rates under states' family planning waiver programs are almost invariably the same as under the broader Medicaid program. Roughly half of the states with family planning waivers adjust their Medicaid rates on an ad hoc basis, depending on state finances and politics. In many states, including Michigan and Pennsylvania, this can result in years-long stretches where rates are left untouched, not even adjusted to keep up with inflation. California and Minnesota both moved to increase their reimbursement rates for family planning services in 2007 after years of stagnation. Health care providers and advocates in California pushed hard for legislation to increase reimbursement rates for family planning providers under Medi-Cal, as rates had not increased significantly since 2000. Minnesota successfully passed legislation calling for a commission to study reimbursement rates for family planning services.

Other states do have systems in place to ensure regular updates to their reimbursement rates. In Mississippi, for example, the majority of Medicaid fees are set at 90% of the Medicare fee schedule, which is adjusted each year by the federal government. Oklahoma now sets its rates at 100% of this schedule, known as the Resource-Based Relative Value Scale. Increased provider rates had been a major budget request for years, because of the state's concern about Medicaid's ability to retain and attract new providers, particularly specialists. In fact, Oklahoma provides enhanced reimbursement to qualified state-employed university providers to facilitate access to primary and specialty care.

South Carolina has taken the unusual step of setting up reimbursement rates for its entire Medicaid program based on the actual costs reported by providers. The goal of such a cost-based system is to fairly and completely reimburse providers for the costs they face in serving clients. South Carolina attempts to achieve this result by setting its reimbursement rates for specific services based on the prior year's reported costs, and then settling up with clinics and readjusting rates at the end of the year. The state is moving toward another, similar concept, called "market-based" rates—setting the reimbursement rate for a specific service at the average cost for the service across the entire provider network—for a certain segment of services. This system would maintain the advantage of reasonable reimbursement while also encouraging clinics to keep their costs down (since they would be paid for that average cost even if, in practice, their own costs were below average). By contrast, a 2004 Guttmacher survey of Title X grantees found that on average, Medicaid reimbursed for merely 54% of the actual cost of a patient's initial family planning visit.²⁸

Acknowledging the labor-intensive patient counseling conducted by dedicated family planning clinics, a few states, including California and Washington, have worked to reward these education and counseling efforts. In

California, the Family PACT program created distinct billing codes for education and counseling services for use by all providers. Washington uses tailored billing codes for clients' annual exams that take specialized education and counseling services into account.

Washington state created a distinct code that providers may use to bill for application assistance to clients, such as explaining the process and verifying information.

Washington state officials report that only two or three out of 100 clients are ultimately rejected after initiating an application at a provider's office. This high success rate may be spurred in part by the fact that the state created a distinct code that providers may use to bill for application assistance to clients, such as answering applicants' questions, explaining the application process, entering application information into the database and verifying information. Oregon took these application assistance services into account as well in setting its rates for a family planning visit, and recently updated its rates to account for the increased cost to clinics of helping clients meet the new citizenship documentation requirement in the application process.

Protecting Client Confidentiality

Although patient confidentiality is an important aspect of any health care program, it is of particular concern to family planning providers. Studies have shown that teens are likely to avoid seeking birth control and other reproductive health services—but to continue having sex—if a parent must be involved in the decision, be it through parental notification or required documentation that only a parent could provide.²⁹ This is not a concern just for teens: Other vulnerable family planning clients, such as victims of domestic abuse or undocumented immigrants, may avoid services out of their own pressing concerns. For these reasons, family planning providers and programs have a rich tradition of finding ways to preserve confidentiality (see box).

Title X, as the only federal source of funding dedicated to family planning, has always been required to preserve patients' confidentiality, and its strategies have become the gold standard for the entire U.S. family planning system. Clinics funded in part through Title X, notably, allow teens to qualify for services based on their own income, rather than on their parents', and have not required clients to provide social security numbers, because teens may not have access to needed documentation without going to a parent.³⁰

Family planning waiver programs have generally adopted these standards. In waiver programs that include teenagers, the teens are allowed to enroll on the basis of their own income. The one exception is South Carolina, which counts household income and requires parental consent to participate, but only for teens younger than 16.

STRATEGIES FOR CONFIDENTIALITY

- Teens enrolled based on their own income
- Second mailing address and phone number allowed
- Privately insured women enrolled when abuse is feared
- Similar enrollment cards throughout all Medicaid programs
- No enrollment card issued
- Electronic warning flags for state data systems

Following another procedure common within the family planning system, states allow program applicants to provide a second mailing address or phone number as a way for the state or a provider to contact them privately. Clients may fail to realize that sensitive health information could be sent to their homes, so many states and providers make a point of explaining the purpose of the alternative address option to their clients.

Some states maintain a 'good cause' exception that allows clients to enroll in the waiver program despite having private insurance when the client fears physical or emotional abuse.

Waiver programs have also had to be innovative to address additional confidentiality issues related to Medicaid broadly or the family planning waivers specifically. For example, the exclusion of privately insured individuals from the programs may pose a hardship to some clients because they fear that using their insurance will violate their privacy (e.g., a statement of benefits might be sent to the policy holder, who may be their husband or father). To get around this problem, some states maintain a "good cause" exception that allows clients to enroll in the waiver program despite having private insurance; this exception is usually limited to cases where the client fears physical or emotional abuse. For instance, the Texas family planning application asks if filing a health insurance claim could cause physical, emotional or other harm and includes a space for a woman to elaborate.

Similarly, enrollment cards—a trademark feature of Medicaid programs across the country—could pose confidentiality concerns for some clients. Carrying a card that explicitly indicates enrollment in a family planning program may be embarrassing, or worse, for some women and men. As result, many states are doing away with distinctive family planning enrollment cards and are instead issuing cards that are only subtly different, or entirely indistinguishable, from those issued to individuals on full-fledged Medicaid. For example, Iowa had a violet-colored Medicaid card for clients with limited benefits (such as those in the family planning program) to distinguish them from clients with full Medicaid coverage. They have since transitioned

to a universal Medicaid card for all users. If the card is indistinguishable from the one used for greater Medicaid, the physicians, clinics, pharmacies and other providers are responsible for checking a state database to identify the benefits to which the client is entitled. (This tactic also allows clients to move back and forth among different Medicaid programs without the state having to issue a new card.) A few states have chosen to continue issuing separate family planning program cards. Illinois and Mississippi maintain separately colored cards to avoid confusion among providers and clients as to the services covered.

Oregon has gone one step further, choosing not to issue enrollment cards at all for its family planning expansion program. State officials report that this idea came directly from focus groups of family planning patients, who wanted greater convenience at the point of service. Oregon's program is particularly well suited to this approach: Participating providers have access to a state database that allows them to check clients' eligibility (and help them submit an application, if they are not yet enrolled). In an effort to ensure that women receive medication in a timely and convenient manner, all prescriptions must be filled on-site. This cuts down on the number of providers (namely outside pharmacists) who must access the system. By program requirement, there is no "scripting out" (writing a prescription to be filled at an outside pharmacy) of oral contraceptives or other contraceptive supplies.

Nevertheless, a no-enrollment-card system could work in a state that does allow scripting out, as long as the state's pharmacies have access to the central database, so that they can confirm that a client is eligible for benefits under the waiver program. In fact, because of such databases (often accessed through a simple Internet connection), a family planning client in many states is able to receive services from any type of provider without having his or her enrollment card on hand.

States' data systems, although extremely helpful in overcoming confidentiality issues and in numerous other ways, can pose their own confidentiality challenges. As data for many different state programs are linked together (with the advantage of easing enrollment, renewal and customer service), situations may occur in which another family member may inadvertently be informed that a woman is enrolled in the family planning waiver program. Some states have responded to this potential problem by creating electronic "flags" for client records, such as messages reminding state caseworkers and health care providers when a woman has requested confidentiality or when changes to the client's record may affect her privacy.

Oregon has chosen not to issue enrollment cards at all for its family planning expansion program—an idea that came directly from focus groups of family planning patients.

Texas officials were acutely aware of these hurdles as they designed and implemented their new multiprogram eligibility system. Having enrollment information for many programs linked together has greatly facilitated the state's adjunctive eligibility system, which allows enrollment in another income-tested welfare program to serve as proof of income. It has also, however, required significant staff training to ensure that, for example, a husband or father is not asked about the family planning waiver program when he calls in an address change for the family's receipt of cash assistance and food stamps or the children's receipt of Medicaid or SCHIP. In response, the state has opted to treat a woman's enrollment in the waiver program as confidential, even if she has not specifically requested it.

Conclusions

In the course of designing and implementing their Medicaid family planning expansions, state officials have demonstrated enormous creativity and surprising entrepreneurship in reaching out to, enrolling and serving new clients. In doing so, they have not only built on, and learned from, earlier generations of Medicaid expansions—including those for pregnancy-related care and SCHIP—but also have taken important and innovative next steps.

For example, while earlier Medicaid expansions developed the concept of presumptive, or temporary, Medicaid eligibility, which enables women to obtain care while a final eligibility determination is still pending, the family planning expansions have taken it a step further by pioneering a range of techniques that either allow women to apply for and be enrolled in the program during their health care visit or allow providers to be reimbursed for care delivered while a client's application is pending. Family planning expansions have also paved new ground in reaching out to high-risk populations via other public programs and using community-based educators; recruiting and training family planning providers using such new technologies as webinars; streamlining the application process by utilizing online application systems and auto-enrolling certain eligible clients; and devoting state funds to pay for clients and services that the federal government will not cover.

These and other innovations and best practices can serve as a guidebook for officials seeking to initiate an expansion in their own state, as well as those looking to improve existing programs. Moreover, many of the issues that policymakers have grappled with as they designed and implemented these expansions—reaching out to new populations, streamlining enrollment and working effectively with a state's provider network—are universal. Therefore, the experiences of these programs hold vital lessons for future generations of Medicaid expansions—even those completely unrelated to family planning—just as the family planning efforts benefited from the experiences of those that came before.

In fact, one significant move toward the future appears to be occurring with little acknowledgment or even conscious design: the emergence of a unified package of reproductive health services under Medicaid.

Currently, many states have three separate expansions of Medicaid—for pregnant women, for family planning and for the treatment of breast and cervical cancer—all of which provide coverage to women up to roughly the same income ceiling. When taken together, they form the core of a comprehensive package of reproductive health care services for large numbers of American women and men who otherwise would not be covered under the program.

These programs hold vital lessons for future Medicaid expansions—even those completely unrelated to family planning—just as the family planning efforts benefited from those that came before.

State and federal officials typically view these efforts in isolation from each other, resulting in unnecessary administrative barriers for individuals needing care, for the providers of that care, and for the officials who shape and run the programs. The auto-enrollment strategy pioneered by the family planning expansions is one key to making the borders between programs transparent. Officials would find it even easier if the family planning expansions, like the other two expansions, could be adopted and renewed without the time- and labor-intensive waiver process, as has been proposed in Congress. A second problem to be overcome is that this existing core package of services leaves out several important reproductive health services—such as preconception care, infertility services, abortion and the testing and treatment of STIs for both women and men.

Three separate expansions of Medicaid—for pregnant women, family planning and breast and cervical cancer—form the core of a comprehensive package of reproductive health care services.

Beyond reproductive health care, the lessons of the family planning expansions are particularly salient now that the issue of health care reform is back on the political table. In response to the ever-rising costs of care and the ever-growing numbers of uninsured Americans, lead-

ers from both political parties have offered competing visions for addressing the nation's patchwork of systems for financing health care. At the state level, the effort in Massachusetts to achieve universal coverage is the most publicized effort, but many other states have made more incremental moves to expand Medicaid, SCHIP and private insurance. Although partisan conflict, fiscal problems and contentious issues such as immigration may make agreement on health care reform difficult to achieve, the prospects for meaningful progress appear to be brighter than they have been since the early 1990s. Any efforts to expand health care coverage for low-income women are likely to build extensively on the framework provided by Medicaid and SCHIP. For this reason, the lessons learned from the Medicaid family planning expansions are both salient and timely, and may help to shape the provision of health care in the United States for decades to come.

References

- 1 Gold RB, Singh S and Frost J, The Medicaid eligibility expansions for pregnant women: evaluating the strength of state implementation efforts, *Family Planning Perspectives*, 1993, 25(5):196–207.
- 2 Guttmacher Institute, State Medicaid family planning eligibility expansions, *State Policies in Brief*, 2008, <http://www.guttmacher.org/statecenter/spibs/spib_SMFPE.pdf>, accessed Mar. 1, 2008.
- 3 Centers for Medicare and Medicaid Services (CMS), *Special Terms and Conditions: Project Number 11-W-00142/0, Oregon Family Planning Expansion Project*, issued by CMS, 2007.
- 4 Swann D, ed., *Family PACT Program Report FY 05/06*, Bixby Center for Reproductive Health Research and Policy, University of California, San Francisco, 2007, <http://www.familypact.org/_Resources/Documents/20070920FamPACTAR0506.pdf>, accessed Jan. 11, 2008.
- 5 Gold RB, Medicaid family planning expansions hit stride, *Guttmacher Report on Public Policy*, 2003, 6(4): 11–14.
- 6 Unpublished tabulations of data from the Rte Care Research and Evaluation Project, 2005.
- 7 Boozman F, *Evaluation of the Women's Health Waiver*, College of Public Health at the University of Arkansas for Medical Sciences, submitted to CMS, 2007.
- 8 Center for Health Services and Policy Research (CHSPR), University of South Carolina, *Interim Evaluation of Project No. 11-W-0057/4 SC Family Planning Waiver: Expansion of Medicaid Benefits for Women Below 185% FPL*, submitted to CMS, 2007.
- 9 O'Neill C, *Healthy Babies: Efforts to Improve Birth Outcomes and Reduce High Risk Births*, Washington, DC: National Governors Association Center for Best Practices, 2004.
- 10 Hall E and Berlin M, *Using Medicaid to Support Preterm Birth Prevention: Five Case Studies*, White Plains, NY: March of Dimes, 2004.
- 11 Edwards J, Bronstein J and Adams K, *Evaluation of Medicaid Family Planning Demonstrations*, The CNA Corporation, submitted to CMS, 2003.
- 12 Frost JJ, Frohwirth L and Purcell A, The availability and use of publicly funded family planning clinics: U.S. trends, 1994–2001, *Perspectives on Sexual and Reproductive Health*, 2004, 36(5):206–215.
- 13 Lindrooth RC and McCullough JS, The effect of Medicaid family planning expansions on unplanned births, *Women's Health Issues*, 2007, 17(2):66–74.
- 14 Kearney MS and Levine PB, Subsidized contraception, fertility, and sexual behavior, *National Bureau of Economic Research (NBER) Working Paper Series*, Cambridge, MA: NBER, 2007, No. 13045.
- 15 Oregon Department of Human Services, *Family Planning Expansion Project, Project Evaluation Report*, submitted to CMS, 2006.
- 16 Foster DG et al., Estimates of pregnancies averted through California's family planning waiver program in 2002, *Perspectives on Sexual and Reproductive Health*, 2006, 38(3):126–131.
- 17 Amaral G et al., Public savings from the prevention of unintended pregnancy: a cost analysis of family planning services in California, *Health Services Research*, 2007, 42(5):1960–1980.
- 18 Frost JJ, Sonfield A and Gold RB, Estimating the impact of expanding Medicaid eligibility for family planning services, *Occasional Report*, New York: Guttmacher Institute, 2006, No. 28.
- 19 Children's Defense Fund, *Outreach Strategies for Medicaid and SCHIP: An Overview of Effective Strategies and Activities*, Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2006.
- 20 Gold RB, Stronger together: Medicaid, Title X bring different strengths to family planning effort, *Guttmacher Policy Review*, 2007, 10(2):13–18.
- 21 Perry M and Paradise J, *Enrolling Children in Medicaid and SCHIP: Insights from Focus Groups with Low-Income Parents*, Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2007.
- 22 Horner D, Lazarus W and Morrow B, *Express Lane Eligibility: How to Enroll Large Groups of Eligible Children in Medicaid and CHIP*, Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 1999.

-
- 23** Horner D and Morrow B, *Opening Doorways to Health Care for Children: 10 Steps to Ensure Eligible but Uninsured Children Get Health Insurance*, Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2006.
- 24** Unpublished data from the National Academy for State Health Policy, 2007.
- 25** Brindis CD et al., Meeting the reproductive health care needs of adolescents: California's family planning access, care, and treatment program, *Journal of Adolescent Health*, 2003, 32(6):79–90.
- 26** National Women's Law Center (NWLC), *Emergency Contraception Coverage under Family Planning §1115 Waivers*, Washington, DC: NWLC, 2007.
- 27** Sonfield A, The impact of anti-immigrant policy on publicly subsidized reproductive health care, *Guttmacher Policy Review*, 2007, 10(1):7–11.
- 28** Sonfield A et al., *Cost Pressures on Title X Family Planning Grantees, FY 2001–2004*, New York: Guttmacher Institute, 2006, <<http://www.guttmacher.org/pubs/2006/08/01/CPTX.pdf>>, accessed Jan. 7, 2008.
- 29** Jones R and Boonstra H, Confidential reproductive health services for minors: the potential impact of mandated parental involvement for contraception, *Perspectives on Sexual and Reproductive Health*, 2004, 36(5):182–191.
- 30** Gold RB, Title X: three decades of accomplishment, *Guttmacher Report on Public Policy*, 2001, 4(1):5–8.

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