STATE HEALTH POLICY BRIEFING

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Medicaid Family Planning Demonstrations: Design Issues and Resources for States

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Since the mid-1990s, 26 states have implemented Medicaid Section 1115 family planning demonstration waivers to help low-income women avoid unintended pregnancy and improve child and maternal health outcomes. These waivers have saved states millions of dollars. The waiver programs, which require approval from the Centers for Medicare and Medicaid Services (CMS), provide access to family planning services for individuals not otherwise eligible for Medicaid or the State Children's Health Insurance Program (SCHIP).

This *State Health Policy Briefing* is the third in a NASHP series examining Medicaid family planning demonstration waivers.[1] It explores some of the design choices states face when applying for and implementing a waiver – choices about whom the program should cover, how it should cover them, and how states can ensure that clients receive the services they need.

Key issues are:

- Eligibility.
- Enrollment – should individuals be automatically enrolled in the program or should they have to apply for coverage?
- Gender – should the program provide services to both women and men?
- Age – at what ages are people eligible?
- Primary care outreach – what mechanisms do states' family planning clinics use to refer clients to primary care physicians and to document that process?

It is important to note that a waiver program may not be needed in every state. For example, some states such as Vermont and Minnesota expanded Medicaid eligibility for parents and children at higher income levels, as well as childless adults, who are rarely covered under Medicaid otherwise. Other states may have existing programs through which women of childbearing age can access family planning services, such as Title X Federal Family Planning Programs. Often, however, these programs operate with low funding.

Eligibility

Eligibility for Medicaid Section 1115 family planning demonstrations varies by state, and follows one of three models:

- extending coverage to women losing Medicaid coverage postpartum,
- extending coverage to those who lose Medicaid for any reason, or
- providing coverage to everyone under a certain income level.

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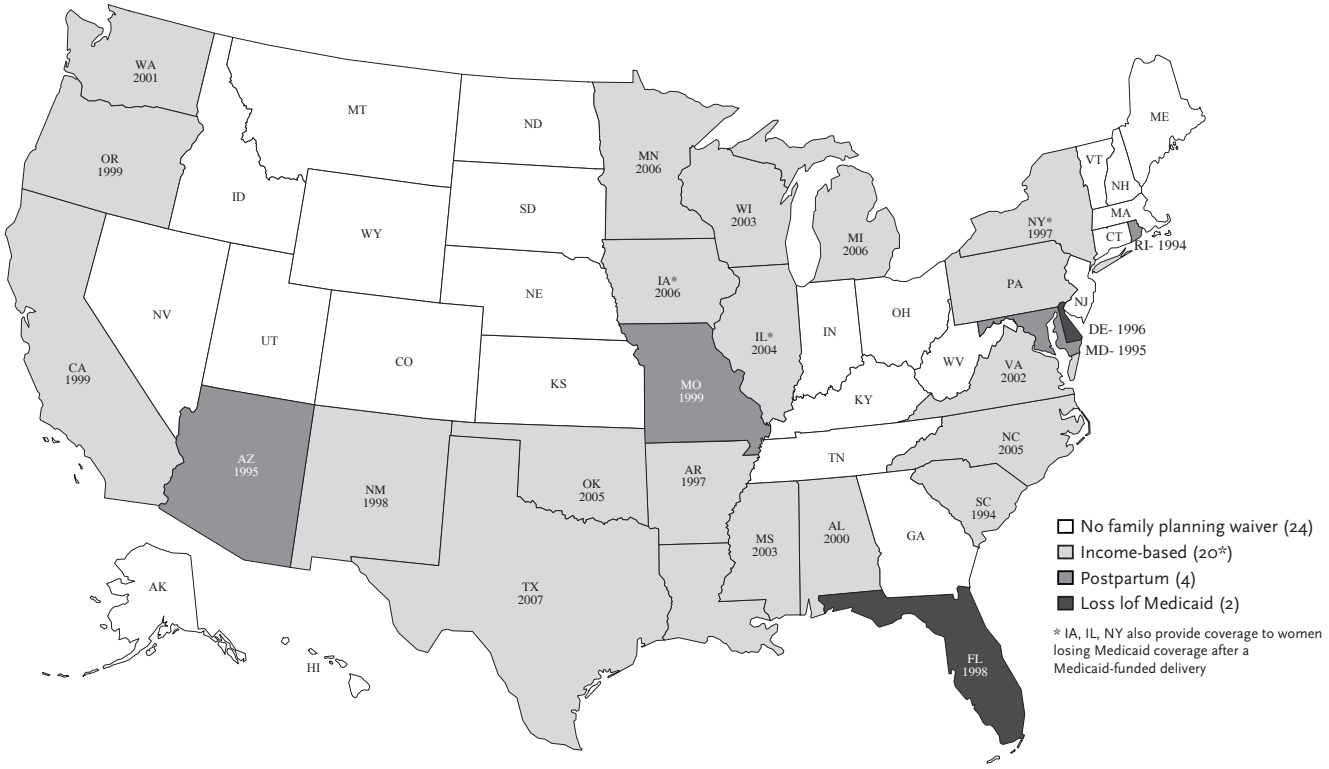
Figure 1. States Using Medicaid Family Planning Waivers, with Year First Implemented



Source: The Guttmacher Institute. *State Policies in Brief: State Medicaid Family Planning Eligibility Expansions.* August 2007. [i]

[i] Available at http://www.guttmacher.org/statecenter/spibs/spib_SMFPE.pdf.

EXTENDING POSTPARTUM COVERAGE

The first Medicaid family planning waiver programs provided coverage to women losing Medicaid coverage after a Medicaid-funded delivery.[2] Under Medicaid, states are required to cover pregnant women up to 133 percent of the federal poverty level (FPL), and may cover women at higher incomes. Coverage includes pregnancy-related care and 60 days of postpartum coverage, after which most women become ineligible for Medicaid. States use these waiver programs to provide extended family planning coverage to this group of women for anywhere from one to five years. The coverage helps women avoid future unintended pregnancies, as well as lengthen the time between planned births. Increased spacing between births is a factor strongly associated with improved maternal and child health outcomes.

FOLLOWING LOSS OF MEDICAID FOR ANY REASON

In May 1995, Delaware received waiver approval from CMS to extend Medicaid family planning coverage to women losing Medicaid for any reason. The state recognized that this population of women is likely to become eligible for Medicaid again if they become pregnant. Access to family planning care was seen as a way to help these women avoid unintended pregnancy, thus providing benefits to both the women and the state. Illinois also instituted a waiver using this model, but later changed it to an income-based program. Florida recently moved to this type of model from one based more narrowly on providing coverage postpartum.

INCOME-BASED

Twenty states use waivers with a broad-based eligibility model. Individuals are eligible for services as long as their incomes are below a certain level, generally up to 185 percent or 200 percent of the federal poverty level (FPL). California began its family planning program with this model in the 1990s using only state funds, and received federal waiver approval in December 1999. Nineteen other states now use income-based eligibility as the basis for enrollment in their

About the National Academy for State Health Policy

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family planning programs.

Because of their broad scope, these waivers are likely to have the highest enrollment levels, and, consequently, accrue the most savings for state Medicaid programs. States provide family planning services not only to women who have recently given birth, but to a larger group of women who would become eligible for Medicaid if they became pregnant. In fact, some states that originally had waivers covering women postpartum, such as South Carolina and New York, have expanded their waivers to income-based eligibility.

Enrollment: Automatic versus Active

In states where women become eligible for waiver services following a Medicaid-funded delivery, an important issue to consider is whether to automatically enroll clients in the program or require them to actively apply for coverage. Automatic enrollment allows eligible women to have immediate coverage for family planning services following pregnancy. Having to apply may dissuade clients from starting or following through with the process, particularly if the application is administratively burdensome or requires in-person appointments. Further, in light of new citizenship documentation requirements, low-income persons may have an even more difficult time applying for Medicaid. The provision, enacted as part of the Deficit Reduction Act of 2005, stipulates that states must ensure that Medicaid enrollees provide proof of their citizenship through documents such as passports, driver's licenses, and birth certificates. Eligible low-income individuals may not always possess or have ready access to these documents. If states use automatic enrollment, though, CMS does allow them to access existing government data to verify enrollees' citizenship, rather than requesting proof of original documents.[3]

At the same time, some states have found that service use is low among women who are automatically enrolled. Women who do not have to complete an application may not be aware of their coverage or interested in accessing family planning care, resulting in lower rates of service use.

For example, Washington State's Take Charge program provides coverage to eligible individuals with incomes at or below 200 percent FPL. The state automatically enrolls into the program women who have Medicaid-funded deliveries, but requires other eligible women and men to actively enroll. An interim evaluation of the state program found that 94 percent of clients who actively enrolled had used services, compared with only 55 percent of women who were automatically enrolled.[4] Likewise, Florida's family planning program first used automatic enrollment, but the state found that a low percentage of enrollees used services. In 2002-03, the last year of Florida's original demonstration period, only 22 percent of enrolled women used services under the waiver.[5] As of 2003, with approval from CMS, the state began requiring women to apply for coverage with the hope of increasing service use.

There may be higher administrative costs involved with active enrollment. However, these costs may be partially offset by the savings to the Medicaid program that accrue as a result of averting births.

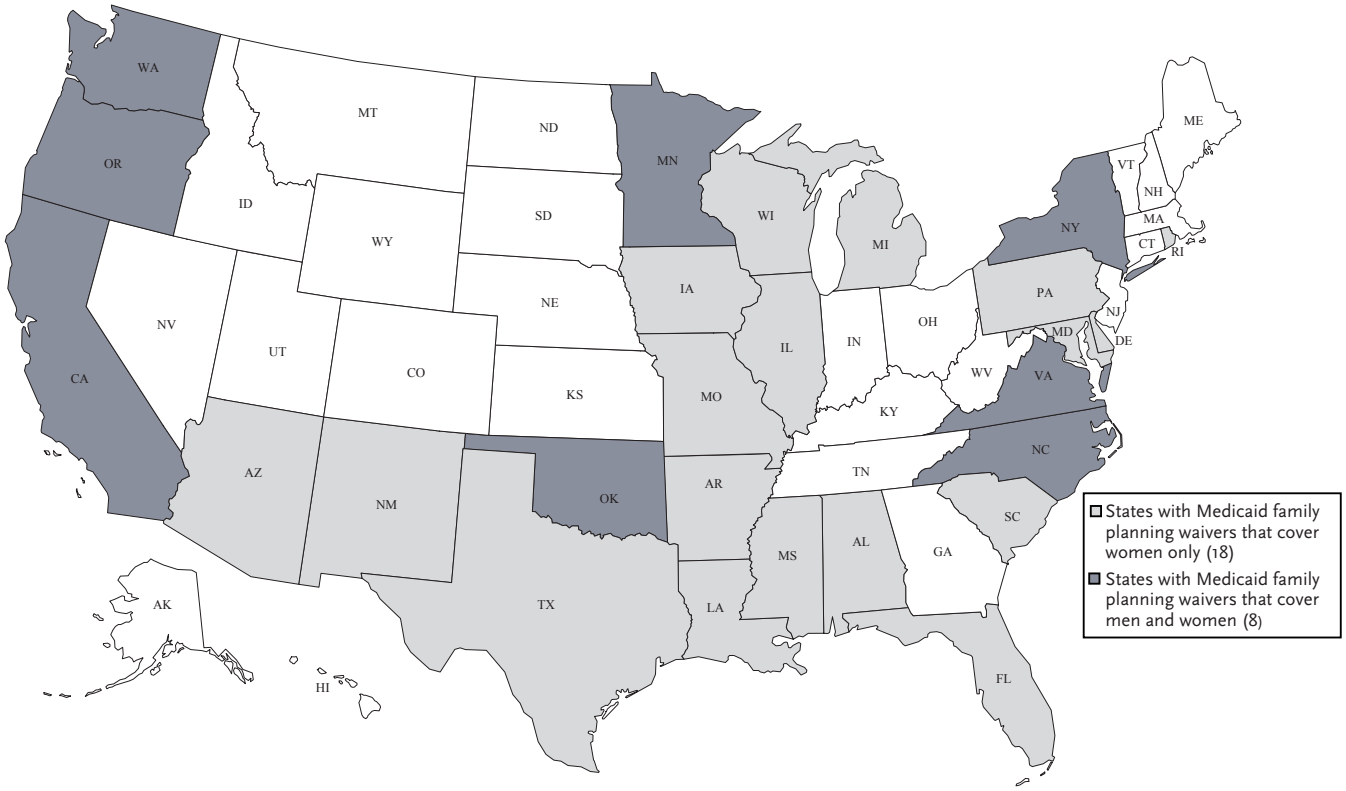
Regardless of whether or not states use automatic enrollment, there are steps they can take to increase enrollment and service use, such as:

- Streamline eligibility criteria by implementing or shifting to an income-based eligibility model.
- Implement presumptive eligibility, which allows for temporarily covering enrollees while their formal eligibility is being determined.
- Create simplified, specialized application forms to expedite the enrollment process, and allow clients to apply at the site of care.
- Use local and statewide media campaigns to encourage enrollment.
- Partner Medicaid family planning programs with state-funded pregnancy prevention programs.
- Target outreach to enrolled individuals to educate them about their coverage
- Target outreach to providers, particularly those who serve high-risk populations, to educate them about the opportunities and limitations of family planning waiver coverage. This may increase provider participation in the program, as well as enlist providers in informing and assisting their patients.

Coverage for Both Men and Women?

Family planning efforts have historically provided services to both men and women, but men comprise a very small proportion of clients. Few reproductive health and family planning initiatives are targeted to them.[6] As a result, many men lack access to the full range of contraceptive options, as well as contraceptive counseling.[7] The Guttmacher Insti-

FIGURE 2. EIGHT STATES COVER BOTH WOMEN AND MEN IN MEDICAID FAMILY PLANNING PROGRAMS



Source: The Guttmacher Institute. *State Policies in Brief: State Medicaid Family Planning Eligibility Expansions.* (August 2007).

tute found that men ages 25-49 are involved in 3.7 million pregnancies annually, 38 percent of which were unplanned.[8] Moreover, research shows that having a partner who supports contraceptive use is associated with more consistent and effective use of contraception, which helps women avoid unintended pregnancies. In addition, family planning services provided to men helps prevent the transmission of sexually transmitted infections.

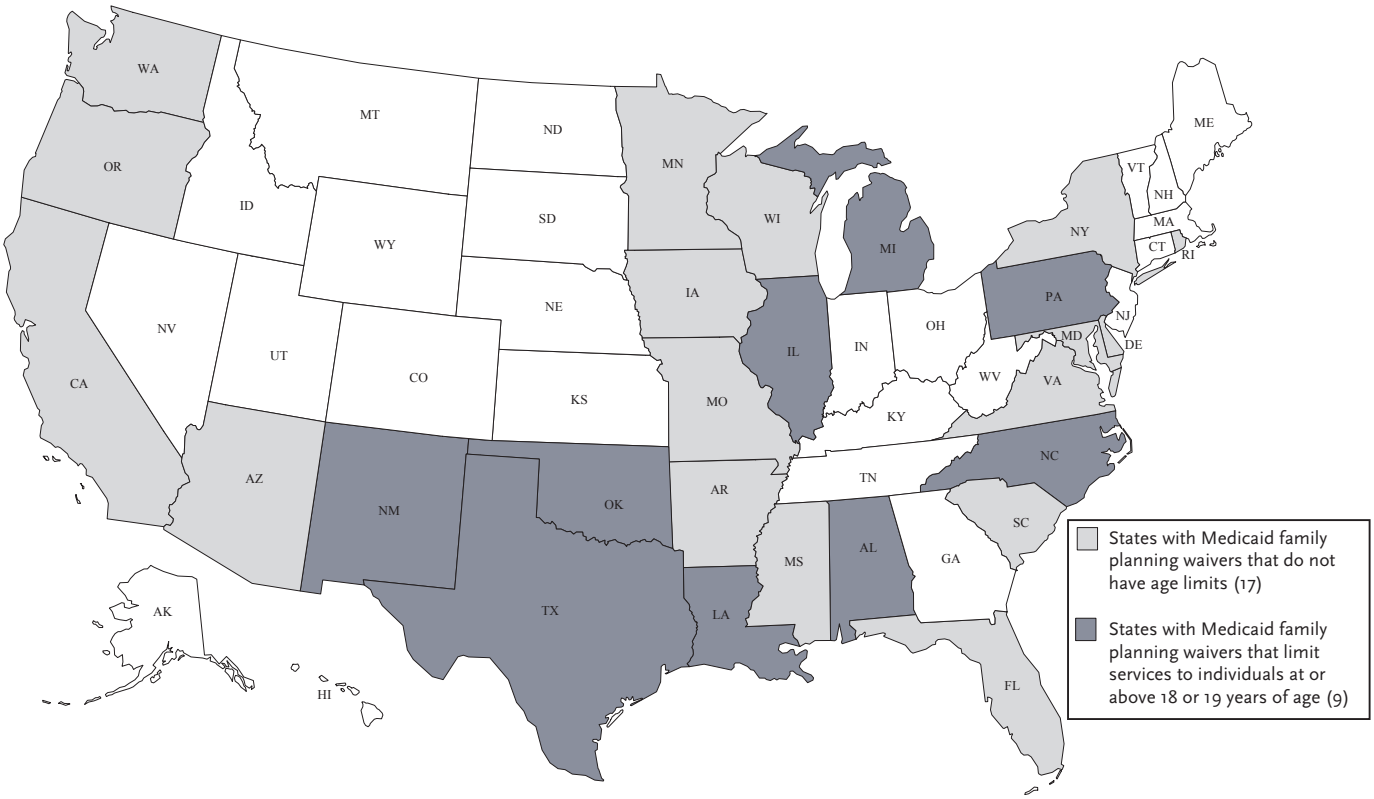
As of October 2007, eight states had Medicaid family planning waivers that cover men as well as women (California, Minnesota, New York, North Carolina, Oklahoma, Oregon, Virginia, and Washington). These states provide a range of family planning services for men, including family planning education, contraceptive counseling, contraception, screening for sexually transmitted infections, and vasectomies.

Age

The majority of states with family planning waivers cover individuals of childbearing age, which is generally defined as ages 15-44, though there is some variation. Two states only cover individuals over age 18 (Pennsylvania, Texas) and seven states only cover individuals over age 19 (Alabama, Illinois, Louisiana, Michigan, New Mexico, North Carolina, and Oklahoma). Some states provide services to individuals at any age who are in need of family planning services.

Excluding teens under the age of 19 from coverage under a waiver may diminish political opposition to family planning program expansions. However, limiting the waiver to individuals over age 18 or 19 can also weaken the state's efforts to reduce unintended pregnancy among an age group with high rates of unintended pregnancy. Eighty-two percent of all teen pregnancies are unplanned, and babies born to teens are more likely to be low-birth weight than babies born to older women with similar risk profiles.[9] Research by the Guttmacher Institute found that almost 750,000 women aged 15-19 become pregnant every year, and, in 2002, there were just over 250,000 pregnancies among 15-17 year olds alone.[10] States that do not restrict eligibility by age may do so because providing teens with access to family planning care through Medicaid waiver programs bolsters efforts to reduce unintended teen pregnancy with all its associated problems and costs: higher school dropout rates, welfare costs, poorer birth outcomes, and generally decreased opportunities for teen parents.

FIGURE 3. NINE STATES LIMIT COVERAGE UNDER MEDICAID FAMILY PLANNING WAIVERS TO INDIVIDUALS AT OR ABOVE 18 OR 19 YEARS OF AGE



Source: The Guttmacher Institute. State Policies in Brief: *State Medicaid Family Planning Eligibility Expansions.* (August 2007).

Primary Care

Since 2001, CMS has required that states establish referral arrangements with primary care providers, so that waiver enrollees can be referred to primary care if necessary. States have not taken a standard approach to addressing this requirement. In general, states develop materials to inform clients about their options for accessing primary care, and family planning providers make referrals to primary care providers when a medical condition over and above family planning is identified during the course of a covered family planning visit. Some states also include letters of support from state community health care and primary care organizations in their waiver applications.

A similar requirement has been part of the Title X Family Planning Program for the past 30 years. Title X is the only federal program devoted solely to providing family planning services to low-income individuals. As a result, this requirement has not been a burden for the many states that rely primarily on Title X clinics to provide services to individuals covered under the family planning waiver. However, outreach to private providers may need to be more intensive in states that allow enrollees to receive family planning care from any Medicaid provider, not just Title X clinics.

In addition, CMS has recently begun requiring states to track whether providers in Medicaid family planning programs are making primary care referrals. This is a challenge for states that do not have systems in place for this type of tracking and documentation.

Information Resources on Family Planning Waivers

States considering seeking a family planning waiver should rely upon officials in states with existing waivers as a resource. With 26 states operating Medicaid family planning waivers, there is a wealth of knowledge and the benefit of lessons learned.

Available information resources include:

RESOURCE LIST

A supplemental list of Resources for Family Planning Waivers is available on the NASHP Web site at: www.nashp.org/Files/FPW_Resources_122007.pdf

CMS MEDICAID WAIVERS AND DEMONSTRATIONS LIST

CMS Medicaid Waivers and Demonstrations List (Waiver applications and materials from states with existing family planning waivers, including evaluations) http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp

ORGANIZATIONS THAT PROVIDE TECHNICAL ASSISTANCE

There are several non-profit organizations, including NASHP, that can help connect state officials with the appropriate contacts in other states, as well as provide targeted assistance to officials seeking to develop and apply for a Medicaid family planning waiver. They include:

- The Guttmacher Institute (www.guttmacher.org)
- National Academy for State Health Policy (www.nashp.org)
- National Family Planning and Reproductive Health Association (www.nfprha.org)

KEY PUBLICATIONS

- The Guttmacher Institute's State Medicaid Family Planning Eligibility Expansions (Updated monthly) http://www.guttmacher.org/statecenter/spibs/spib_SMFPE.pdf
- Estimating the Impact of Expanding Medicaid Eligibility for Family Planning Services (August 2006) http://www.guttmacher.org/pubs/2006/08/16/or28.pdf
- National Women's Law Center, Women and Medicaid Fact Sheet (May 2005) http://www.nwlc.org/pdf/WomenMedicaidUpdateMay2005.pdf
- State Family Planning Administrators (SFPA), Informational Update on State Medicaid Family Planning Waivers (June 2003), available at http://www.sfpainfo.org

Notes

1 For further information on how these programs create significant savings for state Medicaid programs, while helping women avoid unintended pregnancy and improving maternal and child health outcomes, please refer to previous briefs on the topic at www.nashp.org.

2 States are required to cover women for 60 days after a Medicaid-funded delivery.

3 Centers for Medicare and Medicaid Services, Proof of Citizenship Public Law and Final Rule, http://www.cms.hhs.gov/MedicaidEligibility/05_ProofofCitizenship.asp, accessed October 8, 2007.

4 L. Cawthon, T. Keenan-Wilkie, D. Lyons, K Rust, Can Du. "Take Charge Interim Evaluation." Washington State Department of Social and Health Services. Washington: 2005.

5 "Evaluation of Florida's Family Planning Waiver Program: Phase 1, 1998-2003." Maternal Child Health and Education Research and Data Center, College of Medicine, University of Florida. January 5, 2006.

6 F. Sonenstein, editor. Young men's sexual and reproductive health. Washington, DC: The Urban Institute, 2000. Available at: http://www.urban.org/UploadedPDF/young_mens_health.pdf.

7 D. Kalmus and C. Tatum, "Patterns of Men's Use of Sexual and Reproductive Health Services," *Perspectives on Sexual and Reproductive Health, 2007*: (Volume 39, Number 2) p. 74-81.

8 The Guttmacher Institute. *In Their Own Right* (New York: 2002).

9 The Guttmacher Institute. *Facts on American Teens' Sexual and Reproductive Health.*

10 The Guttmacher Institute, U.S. Teenage Pregnancy Statistics: National and State Trends and Trends by Race and Ethnicity, http://www.guttmacher.org/pubs/2006/09/11/USTPstats.pdf, accessed July 23, 2007.