MEDICAID COVERAGE OF FAMILY PLANNING SERVICES:

Results of a National Survey

THE HENRY J. KAISER FAMILY FOUNDATION

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Executive Summary

Introduction

As a major source of health coverage for low-income women of childbearing age, the Medicaid program plays an important role financing family planning services and supplies for millions of women. In recent years, policy changes at both the state and Federal level have begun to alter the financing and delivery of family planning services under Medicaid. Specifically, the growth in Medicaid managed care, with now over half of beneficiaries enrolled, may have increased enrollees' access to private-sector primary care providers and gynecologists. This shift, however, may also have made it more difficult for women to use traditional sources of contraceptive services, such as family planning clinics. Many states have also begun to establish special Medicaid financed family planning programs that extend coverage to women who lose their Medicaid because they no longer qualify for coverage or to other low-income women who were previously ineligible for assistance.

Because Medicaid is both a state and Federal program, it is necessary to know what is happening at the state level to gain a national picture of the program. To better understand how family planning services are operating under Medicaid, The Henry J. Kaiser Family Foundation contracted with Health Systems Research, Inc. to conduct a comprehensive survey on access to family planning services in the 50 states and the District of Columbia. The major purposes of the study were to gather information on the coverage and delivery of family planning services in Medicaid programs, and to identify the critical policy and program issues that affect access to these services.

Methods

To collect this information, HSR conducted telephone interviews in all 51 jurisdictions using standard interview protocols from August 1999 through January 2000. In each state, Medicaid officials with oversight of family planning services; Representatives of public health agencies that oversee the distribution of other sources of funds for family planning (such as Title X, the Federal Family Planning Program; Title XX, the Social Services Block Grant; Title V, the Maternal and Child Health Block Grant; or state funds); and a representative of a clinic association or major provider of family planning services to low-income women and men were contacted in each state.

Background information was also gathered from the states, including Medicaid managed care contracts, statutory or regulatory language, and statistical reports. Medicaid officials in 48 states agreed to be interviewed, as did public health officials in 47 states, and clinic representatives in 34 states. Medicaid officials in Mississippi, New Mexico, and Wyoming did not respond to the

survey. Public health officials were not available for interviews in the District of Columbia, Louisiana, Montana, or South Carolina. The information collected from each informant was catalogued and analyzed in a database using Microsoft Access.

Findings

I. Medicaid Coverage of Family Planning Services

Services defined by a state as "family planning" are eligible for federal matching funds at a rate of 90 percent. Although the Health Care Financing Administration (HCFA)[1] has never formally defined "family planning," its guidelines permit a wide range of services to fall into this category. Moreover, states can classify some services, such as gynecological exams or pregnancy tests, as family planning services only if they are provided during a family planning visit.

- All responding states cover gynecological exams, often as a family planning service; nearly all cover prescription contraception, sterilization services (tubal ligation, 46 and DC; vasectomy, 45 and DC), screening and treatment for sexually transmitted diseases (44 and DC and 42 and DC respectively).

- Less commonly covered are contraceptive counseling (36 and DC, although some of these states provide it as part of an office visit), over-the-counter contraception including condoms, spermacide and sponges (33 and DC), preconception counseling (22 and DC) and infertility testing (9 and DC) and treatment (3 and DC). State Medicaid coverage of family planning services, while generally quite comprehensive, varies by category of service.

- Many states are not be taking full advantage of the opportunity to receive the enhanced federal matching rate for family planning services—many do not cover all of the services that may be classified as family planning, and some do not report using the coding category of "family planning" to receive a 90 percent federal matching rate at all.

II. Family Planning and Medicaid Managed Care

Of the 48 Medicaid programs that responded to the survey, all but one use some type of managed care strategy to serve women of childbearing age. In fact, forty-two states provide services through capitated health maintenance organizations (HMOs). While these programs offer the potential benefit of a consistent primary care provider, they also bring concerns in the area of family planning: managed care organizations may not offer a comprehensive package of family planning services if contract language is not specific; provider networks may not include traditional family planning providers; and plans may be owned by faith-based organizations or may include faith-based providers who choose not to provide family planning services.

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[1] Since the time of the survey, HCFA has been renamed the Centers for Medicare and Medicaid Services (CMS). Given that it was called HCFA during the period of the survey, this report uses the former agency name.

- Despite a federal requirement that states assure "open access" to any Medicaid-certified family planning provider for family planning services in states with mandatory Medicaid managed care (states whose programs operate under section 1115(a) research and demonstration waivers may waive this provision), state public health officials and reproductive health agency representatives in most states reported that they did not feel that enrollees in their state fully understood their right to open access to family planning.

- Moreover, many respondents felt that the availability of family planning services outside of the plan's network, although it offers confidentiality and access to services in the community, presents an inherent tension with managed care's goals of continuous care coordinated by a central primary care provider.

- Access to family planning services can be further complicated when Medicaid managed care plans refuse to provide family planning services on religious grounds. Under the Balanced Budget Act of 1997, Medicaid managed care plans are permitted to refuse "to provide, reimburse for, or provide coverage of counseling or referral services."
- Seven states reported that they contract directly with faith-based plans that do not provide one or more types of family planning services, typically including contraception, abortion, and/or sterilization, and several more indicated that faith-based providers are included in plans' networks (8 states). Thus, the number of women affected by faith-based providers is likely to be great.

As states shift to Medicaid managed care systems, they gain the ability and the responsibility to monitor the services these systems provide. However, despite the increased attention aimed at quality assurance, there remains a dearth of information regarding the effect of managed care systems on the quality of family planning services clients receive.

- Few standard measures of the quality of family planning services currently exist, and family planning measures are absent from standard quality monitoring tools and surveys.
- Few states indicated that they are using billing or other data to analyze Medicaid enrollees' patterns of family planning service use, while nearly half of the states indicated that they do not collect data that would allow for this analysis and have no plans to do so in the future.

III. Medicaid Family Planning Expansions

States may also use Medicaid financing to provide coverage for family planning services to targeted groups of people who would otherwise not be eligible for Medicaid. These programs most often cover women who would otherwise lose eligibility for Medicaid after the postpartum period, or they expand eligibility for family planning services to all women who meet an increased income standard, regardless of previous enrollment in Medicaid.

- Family planning waivers benefit packages vary: some cover only those services that are directly related to contraception, while others have included a more comprehensive set of services in their programs' benefits.

- At the time of the survey, twelve states were operating statewide expanded family planning programs under section 1115(a) waiver authority (AR, AZ, CA, DE, FL, MD, MO, NY, NM, RI, OR, SC) and at least six more states were developing or had submitted waiver applications (AL, CO, NC, OK, WI, WA).
- Most of the states currently operating family planning waivers are in the process of evaluating these new programs. While data are not yet available from most of these evaluations, promising results have been reported: one state (MD) saw a reduction in the rate of unplanned pregnancies and births among Medicaid enrollees during the program's first two years, and another noted a decrease in the percentage of Medicaid enrollees with interpregnancy intervals of less than 18 months (RI).

Conclusions

The findings of this survey paint a complex picture of the systems low-income women and men rely on for family planning services. A number of these findings give cause for concern about access to family planning and its consistency across the states:

- Although Medicaid covers a broad range of services, states vary substantially in the family planning services covered under their Medicaid programs and in the information provided to the program's enrollees about these services.
- State programs and policies to increase access to family planning services including waiver program and managed care freedom of choice provisions many not be implemented in ways that expand access. Managed care enrollees may not be informed about their rights to use out-of-plan providers, an issue that is particularly important to women who are enrolled in faith-based plans or using faith-based providers that do not provide them with family planning services and supplies. For open access provisions to be effective, Medicaid enrollees must be made aware of their right to use providers outside of their plans' networks.
- State officials are largely unaware of the effect of managed care arrangements on access to and use of family planning services. Although there have been many efforts to improve monitoring under managed care generally, few mechanisms are in place to measure the quality of family planning services for Medicaid beneficiaries under managed care.
- Despite the critical importance of family planning to the success of welfare reform, the connections among TANF programs, Medicaid agencies, and family planning clinics are tenuous.
- The various sources of funding for family planning services, including Medicaid, Title X, Title V, Title XX, and state funds, are typically not well coordinated, and many states do not take full advantage of the availability of the 90 percent match for Medicaid-funded family planning services, losing potential Federal revenues.

Chapter I: Introduction and Overview

I. Introduction and Overview

Medicaid, the health insurance program for low-income Americans administered jointly by the states and the Federal government, is a major provider of health coverage for women of childbearing age, covering six million low-income women between the ages of 15 and 44 (Gold, 1999). For women who are not pregnant, Medicaid's income eligibility thresholds are typically quite low, as they are based on states' eligibility standards for cash assistance. Family planning services are essential for these women, both for their health and for their ability to join and remain in the workforce. Medicaid's support for these services is critical for women who lack the means to pay for family planning services and supplies.

The Federal Medicaid program has long emphasized family planning. In 1972, the Title XIX statute was amended to require that state Medicaid programs cover family planning services and supplies for categorically eligible beneficiaries. The importance of these services was reinforced by the establishment of a Federal matching rate of 90 percent, rather than the usual 50 to 80 percent, for family planning services.

However, changes in Medicaid policy at both the state and Federal levels are shifting the way family planning services are delivered and financed under Medicaid. In 1999, 56 percent of Medicaid enrollees were served through capitated managed care organizations, compared to 14 percent in 1993 (HCFA, 1999). This proportion is likely to be much higher for women of reproductive age, since the categories through which they qualify for Medicaid are those most frequently required to enroll in managed care plans. The use of managed care to deliver services to Medicaid enrollees has the potential to increase their access to private-sector primary care providers and gynecologists, but may also make it more difficult for women to use the traditional sources of family planning services, such as free-standing family planning clinics and community health centers, on which they have traditionally relied.

In addition, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA, or "welfare reform") has complicated women's access to Medicaid coverage. Welfare reform severed the connection between Medicaid eligibility and receipt of cash assistance and imposed limits on the length of time families could receive cash benefits. Although Medicaid eligibility is not subject to these time limits and its eligibility standards have not changed, confusion on this point is common, and analysts have noted significant declines in Medicaid enrollment since the implementation of welfare reform (Schlosberg and Ferber, 1998; Ellwood, 1999). These declines have been particularly notable for women of reproductive age and their children. Between 1994 and 1998, the proportion of women of reproductive age enrolled in Medicaid fell from 12.6 percent to 9.9 percent, a decline of 21 percent (Gold, 1999). Significant declines in the percentage of women ages 15 to 44 covered by Medicaid were seen in 23 states over this time period.

These changes in Medicaid policy and programs are beginning to be reflected in the program's total expenditures for family planning and the number of beneficiaries receiving those services.

In fiscal year 1998, the Medicaid program reported providing family planning services to just over 2 million recipients for a total expenditure of $449 million (HCFA, 2000). This represents a decline since FY 1994, when HCFA reported 2.6 million users of family planning services and an expenditure of more than $500 million. In addition, over this period, total Medicaid expenditures rose from $108.3 billion in 1994 to $142.3 billion in 1998, while the amount spent on family planning remained stable or declined (HCFA, 2000). However, these figures do not include users and expenditures under capitated managed care programs since the data are not easily collected, nor separated out for reporting purposes. As these programs have grown, it has become more difficult to determine the number of Medicaid recipients who are using family planning services and the amount the states and the Federal government spend on these services.

To explore the provision of family planning under Medicaid in more detail, The Henry J. Kaiser Family Foundation contracted with Health Systems Research, Inc. to conduct a comprehensive survey on access to family planning services in the 50 states and the District of Columbia. The major purposes of the study were, first, to gather baseline information on the coverage and delivery of family planning services in these 51 jurisdictions' Medicaid programs, and second, to identify the critical policy and program issues that affect access to these important services.

To collect this information, HSR conducted telephone interviews in all 51 jurisdictions using standard interview protocols from August 1999 through January 2000. At least three informants were contacted in each state:

- Medicaid officials responsible for family planning;
- Representatives of public health agencies that oversee the distribution of other sources of funds for family planning, such as Title X, the Federal Family Planning Program; Title XX, the Social Services Block Grant; Title V, the Maternal and Child Health Block Grant; or state funds; and
- A representative of a clinic association or major provider of family planning services to low-income women and men.

In addition to these telephone interviews, background information was gathered from the states, including Medicaid managed care contracts, statutory or regulatory language, and statistical reports. The information collected from each informant was catalogued and analyzed in a database using Microsoft Access.

This study encountered several challenges. First, not all states participated fully in the study. Medicaid officials in 48 states agreed to be interviewed, as did public health officials in 47 states, and clinic representatives in 34 states. Medicaid officials in Mississippi, New Mexico, and Wyoming did not respond to the survey. Public health officials were not available for interviews in the District of Columbia, Louisiana, Montana, or South Carolina.

Second, it was often the case that no single informant in a state Medicaid agency was fully conversant in issues related to family planning, managed care programs, and financing. The compartmentalization of these agencies often means that no one staff member is aware of all of the forces affecting access to family planning services. Therefore, in some cases a range of Medicaid officials were interviewed, while in others, it was not possible to gather full information on all of the topics covered in the survey protocol. In addition, even those officials

who could report on coverage of services were only able to describe those services that have been assigned distinct billing codes; that is, some services may be provided as part of an office visit, but are not separately billable.

Medicaid coverage for abortion has long been a source of controversy on both the state and local levels. Although never considered a family planning service for Federal matching purposes, abortion is covered in many states using both state and Federal Medicaid funds, often using the two funding sources under different circumstances. Though an important family planning issue, this report will not cover Medicaid coverage for abortion services.

This report presents the findings of the study. The next chapter discusses the family planning services provided by the Medicaid program. The following chapter focuses specifically on issues related to the provision of family planning under Medicaid managed care, including the services covered under Medicaid managed care contracts, access issues, payment provisions, and quality assurance and evaluation. Chapter IV examines the use of section 1115(a) waivers to extend Medicaid eligibility for family planning services, an emerging strategy for increasing access to services. Chapter V discusses the broader systems in which these Medicaid programs operate, including the public health safety net systems that have traditionally provided family planning services to low-income women. Chapter VI highlights respondents' perspectives and the concluding chapter presents the lessons learned from this survey.

Chapter II: What is Family Planning?

II. What is Family Planning?

Despite the Medicaid program's emphasis on family planning services, the Health Care Financing Administration (HCFA) has never formally defined "family planning." The State Medicaid Manual explains that the Medicaid statute and regulations do not define this service; therefore, no specific guidelines or regulations exist to determine which family planning services must be provided under state Medicaid programs, which are eligible for the 90 percent Federal match, or which must be included under Medicaid managed care contracts. Nonetheless, the services classified as "family planning" are important to state Medicaid agencies, managed care organizations, and community-based providers, as this definition governs a range of policies, from matching rates to access provisions.

A. Services Covered by Medicaid

Reproductive health care for women and men encompasses a range of types of services, from counseling to physical exams to the direct provision of contraceptive methods. State Medicaid coverage of these services, while generally quite comprehensive, varies significantly across these service categories; for example, states are much more likely to cover medical procedures related to contraception than to pay for screening and treatment of infertility.

States also vary in the lists of covered services they define as "family planning." Services defined by a state as family planning services are eligible for Federal match (or "FFP," for Federal Financial Participation) at a rate of 90 percent. Although specific guidance is not provided, the Medicaid State Operations Manual provides a general list of the types of services that are eligible for the 90 percent match:

> "In general, FFP at the 90 percent matching rate is available for the costs of counseling services and patient education, examination and treatment by medical professionals in accordance with applicable State requirements, laboratory examinations and tests, medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception, and infertility services, including sterilization reversals." (HCFA, 1988)

Subsequent guidance from HCFA in 1993 clarified the circumstances in which specific services could be claimed as family planning services. These guidelines include the following:

- Services intended to prevent or delay pregnancy, including counseling, laboratory tests, medical procedures, and pharmaceutical supplies and devices are considered to be family planning services. Sterilization and infertility treatment are considered to be family planning as well.
- Procedures performed for medical reasons, rather than to delay or prevent pregnancy, are not considered to be family planning. For example, colposcopy, biopsy, and cryotherapy for cervical dysplasia are treatments for a medical condition, not family planning

services. Removal of an IUD due to a pelvic infection would likewise be considered a medical procedure and would be matched at the standard rate.

- Hysterectomy and abortion are not considered family planning services.
- Pregnancy testing may be considered to be family planning if it is conducted as part of an initial or annual family planning examination or if it is conducted in a family planning clinic.
- Services conducted as part of an inpatient hospital stay, such as a tubal ligation, may be considered to be family planning, but the entire hospital charge would not be eligible for the 90 percent match. States must develop a methodology for allocating the appropriate portion of the cost of a hospital stay to the family planning service.

Following this guidance, many states have established two categories of family planning services: one set of services that is always considered to be related to family planning, and another that is put in this category only when provided in the context of a family planning visit. These two groups of services are discussed below:

- **Exams and counseling services** (Table II-1). While all states cover gynecological exams, many states reported that their Medicaid programs did not have explicit billing codes for contraceptive counseling and reproductive health education. Eleven states do not cover contraceptive counseling as a distinct service, and 17 have no billing code for reproductive health education. In many of these cases, state officials assumed that these services were being conducted in family planning clinics in the course of a family planning visit. However, it is difficult to assess whether or not these services are being provided consistently and appropriately.

  Examination, counseling, screening, and treatment services are unlikely to be uniformly considered family planning services. In these cases, many states reported that for the service to be classified as family planning, claim forms would have to be marked to indicate that these services were provided in the context of a family planning visit, or they would have to be filed by a family planning clinic provider. For example, only 18 states consistently classify gynecological exams as family planning, while 27 will do so if provided during a family planning visit; and 15 states classify Pap smears and lab services as family planning in all cases, while 24 will do so only in the context of a family planning visit.

- **Prescription contraception** (Tables II-2 and II-3). Nearly all states in the survey reported covering both the medical procedures and supplies involved in providing all currently approved prescription methods of contraception, including oral contraceptives, intrauterine devices, contraceptive implants and injections, and diaphragms. (Vermont also reported covering cervical caps.) A few states, however, were not consistent in their coverage. Louisiana covers all medical procedures, but not all of the supplies, and South Dakota and North Carolina cover all methods but diaphragms. Finally, coverage for emergency contraception, or methods of preventing pregnancy after unprotected intercourse (approved by the Food and Drug Administration in 1998), is less universal; only 27 states and DC reported covering this service.

Table II-1

State Medicaid Programs' Coverage of Family Planning Services: Exams and Counseling

State	Gyn Exams	Contraceptive Counseling	Reproductive Health Education
United States Total	48	37	31
Alabama	⊙	⊙	⊙
Alaska	⊙	-	-
Arizona	●	●	●
Arkansas	●	●	●
California	⊙	●	⊙
Colorado	●	●	●
Connecticut	○	○	○
Delaware	⊙	-	-
District of Columbia	○	●	-
Florida	⊙	●	-
Georgia	⊙	●	●
Hawaii	⊙	⊙	⊙
Idaho	●	●	●
Illinois	⊙	-	-
Indiana	●	-	-
Iowa	⊙	-	-
Kansas	⊙	●	●
Kentucky	⊙	⊙	⊙
Louisiana	●	●	-
Maine	⊙	●	⊙
Maryland	⊙	●	-
Massachusetts	⊙	●	-
Michigan	⊙	○	○
Minnesota	⊙	●	●
Mississippi	- - -	- - -	- - -
Missouri	⊙	⊙	⊙
Montana	●	●	●
Nebraska	⊙	○	-
Nevada	⊙	●	●
New Hampshire	●	●	●
New Jersey	⊙	●	○
New Mexico	- - -	- - -	- - -
New York	⊙	●	○
North Carolina	⊙	⊙	⊙
North Dakota	●	●	●
Ohio	●	-	-
Oklahoma	●	-	-
Oregon	●	●	●
Pennsylvania	●	●	●
Rhode Island	●	●	●
South Carolina	●	●	-
South Dakota	●	-	-
Tennessee	●	●	●
Texas	⊙	⊙	⊙
Utah	●	-	-
Vermont	⊙	●	●
Virginia	⊙	-	○
Washington	⊙	⊙	⊙
West Virginia	○	-	-
Wisconsin	⊙	⊙	⊙
Wyoming	- - -	- - -	- - -

Notes: ●=Always considered Family Planning
⊙=Sometimes considered family planning depending on context of visit
○=Covered, but never defined as Family Planning
- =Service not covered
- - - =States did not respond to survey
As of January 2000

Table II-2.

State Medicaid Programs' Coverage of Family Planning Services: Medical Procedures and Prescription Contraception

State	IUDs	IUD Insertion	IUD Removal	Implants	Implant Insert	Implant Removal
United States Total	**47**	**48**	**48**	**48**	**48**	**48**
Alabama	⊙	●	●	⊙	●	●
Alaska	●	●	●	●	●	●
Arizona	●	●	●	●	●	●
Arkansas	●	●	●	●	●	●
California	●	●	●	●	●	●
Colorado	●	●	●	●	●	●
Connecticut	●	●	●	●	●	●
Delaware	●	●	●	●	●	●
District of Columbia	●	●	●	●	●	●
Florida	●	●	●	●	●	●
Georgia	●	●	●	●	●	●
Hawaii	●	●	●	●	●	●
Idaho	●	●	●	●	●	●
Illinois	●	●	●	●	●	●
Indiana	●	●	●	●	●	●
Iowa	●	●	●	●	●	●
Kansas	●	●	●	●	●	●
Kentucky	⊙	⊙	⊙	⊙	⊙	⊙
Louisiana	-	●	●	●	●	●
Maine	●	●	●	●	●	●
Maryland	●	●	●	●	●	●
Massachusetts	●	●	●	●	●	●
Michigan	●	●	●	●	●	●
Minnesota	●	●	●	●	●	●
Mississippi	- - -	- - -	- - -	- - -	- - -	- - -
Missouri	●	●	●	●	●	●
Montana	●	●	●	●	●	●
Nebraska	●	●	⊙	●	●	⊙
Nevada	●	●	●	●	●	●
New Hampshire	●	●	●	●	●	●
New Jersey	●	●	⊙	●	●	⊙
New Mexico	- - -	- - -	- - -	- - -	- - -	- - -
New York	●	●	●	●	●	●
North Carolina	●	●	●	●	●	●
North Dakota	●	●	●	●	●	●
Ohio	●	●	●	●	●	●
Oklahoma	●	●	●	●	●	●
Oregon	●	●	●	●	●	●
Pennsylvania	●	●	●	●	●	●
Rhode Island	●	●	●	●	●	●
South Carolina	●	●	●	●	●	●
South Dakota	●	●	●	●	●	●
Tennessee	●	●	●	●	●	●
Texas	⊙	⊙	⊙	⊙	⊙	○
Utah	●	●	●	●	●	●
Vermont	●	●	●	●	●	●
Virginia	●	●	●	●	●	●
Washington	●	●	●	●	●	●
West Virginia	○	○	○	○	○	○
Wisconsin	⊙	⊙	⊙	⊙	⊙	⊙
Wyoming	- - -	- - -	- - -	- - -	- - -	- - -

Notes: ●=Always considered Family Planning
⊙=Sometimes considered family planning depending on context of visit
○=Covered, but never defined as Family Planning
- =Service not covered
- - - =States did not respond to survey
As of January 2000

Table II-3

State Medicaid Programs' Coverage of Family Planning Services: Medical Procedures and Prescription Contraception (Continued)

State	Injectable	Injection	Diaphragm	Diaphragm Fitting	Oral Contraceptives	Emergency Contraceptive Pill
United States Total	**48**	**47**	**45**	**47**	**48**	**28**
Alabama	O	●	●	●	O	-
Alaska	●	●	●	●	●	●
Arizona	●	●	●	●	●	●
Arkansas	●	●	●	●	●	-
California	●	●	●	●	●	●
Colorado	●	●	●	●	●	-
Connecticut	●	●	●	●	●	-
Delaware	●	●	●	●	●	●
District of Columbia	●	●	●	●	●	●
Florida	●	●	●	●	●	-
Georgia	●	●	●	●	●	●
Hawaii	●	●	●	●	●	●
Idaho	●	●	●	●	●	-
Illinois	●	●	●	●	●	-
Indiana	●	●	●	●	●	●
Iowa	●	●	●	●	●	-
Kansas	●	●	●	●	●	-
Kentucky	O	O	O	O	O	O
Louisiana	●	●	-	●	●	-
Maine	●	●	●	●	●	-
Maryland	●	●	●	●	●	O
Massachusetts	●	●	●	●	●	●
Michigan	●	●	●	●	●	●
Minnesota	●	●	●	●	●	-
Mississippi	---	---	---	---	---	---
Missouri	●	●	●	●	●	●
Montana	●	●	●	●	●	-
Nebraska	●	●	●	●	●	●
Nevada	●	●	●	●	●	●
New Hampshire	●	●	●	●	●	-
New Jersey	●	●	●	●	●	●
New Mexico	---	---	---	---	---	---
New York	●	●	●	●	●	●
North Carolina	●	●	-	●	●	●
North Dakota	●	●	●	●	●	●
Ohio	●	●	●	●	●	-
Oklahoma	●	●	●	●	●	-
Oregon	●	●	●	●	●	●
Pennsylvania	●	●	●	●	●	●
Rhode Island	●	●	●	●	●	●
South Carolina	●	●	●	●	●	●
South Dakota	●	●	-	-	●	-
Tennessee	●	●	●	●	●	-
Texas	O	O	O	O	O	-
Utah	●	●	●	●	●	O
Vermont	●	●	●	●	●	●
Virginia	●	●	●	●	●	●
Washington	●	●	●	●	●	●
West Virginia	O	O	●	O	O	-
Wisconsin	O	O	●	O	O	O
Wyoming	---	---	---	---	---	---

●=Always considered Family Planning
O=Sometimes considered family planning depending on context of visit
O=Covered, but never defined as Family Planning
- =Service not covered
- - - =States did not respond to survey
As of January 2000

Medical procedures directly related to contraception, prescription and over-the-counter contraceptive supplies, and sterilizations are most likely to be categorically classified as family planning. Of the states that cover these services, nearly all consider them to be family planning services in all cases. Specifically:

Forty-three states and DC consider the medical procedures they cover (including IUD insertion and removal, implant insertion and removal, contraceptive injections, and diaphragm fitting) to be family planning services in all cases; only four classify these services as family planning under specific circumstances. (For example, Wisconsin classifies as family planning only those services provided in a family planning clinic.) In addition, New Jersey would not consider the removal of an IUD to be a family planning service if it were performed for medical reasons.

Forty-two states and DC consistently classify prescription contraceptive supplies as family planning, and four do so in some circumstances. Similarly, 38 states and DC classify the over-the-counter supplies they cover as family planning, while Wisconsin does so only when provided by a family planning clinic. Finally, of the 28 jurisdictions that cover emergency contraception, 23 states and DC classify this as family planning in all cases, while four (Kentucky, Maryland, Utah, and Wisconsin) do so in certain circumstances.

Other services may also be defined as family planning: for example, Kansas includes treatment of incomplete abortions in this category; Arkansas, Colorado, Oklahoma and West Virginia include pregnancy testing; and Rhode Island includes postpartum rubella immunizations, anemia testing, and cryosurgery.

- **Over-the-counter contraception** (Table II-4). Thirty-two states and DC reported covering certain over-the-counter methods and supplies, consisting of condoms, spermicide, and sponges (when available). In addition, Alaska, New York, Texas, and Wisconsin reported covering female condoms, and Kentucky, New York, Pennsylvania, Texas, Vermont, and Wisconsin cover the basal thermometers needed for natural family planning. Of the remaining eight states, five (Maine, Missouri, North Carolina, Tennessee, and Utah) cover no over-the-counter methods, and Delaware and Vermont cover spermicide but not condoms.

- **Sterilization** (Table II-5). Sterilization services for both women and men are covered by the majority of Medicaid programs. Tubal ligation may be provided during the immediate postpartum period or separately from delivery or other surgery; the latter is known as "interval" sterilization. Each type of procedure is covered by 46 states and DC, while Oregon will cover this procedure only after delivery and Alabama only on an interval basis. Vasectomy is covered by 45 states and DC, all but Idaho and South Dakota.

  Sterilization services are likely to be classified as family planning services for the purpose of the 90 percent match. Of the programs that cover these services, 40 states and DC always classify interval tubal ligations as family planning, 41 states and DC do

Table II-4

State Medicaid Programs' Coverage of Family Planning Services: Over-the-Counter Supplies

State	Condoms	Spermicide	Sponges	Other
United States Total	**39**	**42**	**37**	**7**
Alabama	●	●	-	-
Alaska	●	●	●	● Female condom
Arizona	●	●	-	-
Arkansas	●	●	-	-
California	●	●	●	-
Colorado	●	●	●	-
Connecticut	●	●	●	-
Delaware	-	●	●	-
District of Columbia	●	●	●	-
Florida	●	●	●	-
Georgia	●	●	●	-
Hawaii	●	●	●	-
Idaho	●	●	●	-
Illinois	●	●	●	-
Indiana	●	●	●	-
Iowa	●	●	●	-
Kansas	●	●	●	-
Kentucky	-	●	●	O Thermometers
Louisiana	●	●	-	-
Maine	-	-	-	-
Maryland	●	●	●	-
Massachusetts	●	●	●	-
Michigan	●	●	●	-
Minnesota	●	●	●	-
Mississippi	- - -	- - -	- - -	- - -
Missouri	-	-	-	-
Montana	●	●	●	-
Nebraska	●	●	-	-
Nevada	●	●	●	-
New Hampshire	●	●	●	-
New Jersey	●	●	●	-
New Mexico	- - -	- - -	- - -	- - -
New York	●	●	●	O Thermometers, Female condoms
North Carolina	-	-	-	-
North Dakota	●	●	●	-
Ohio	●	●	●	-
Oklahoma	●	●	●	-
Oregon	●	●	●	-
Pennsylvania	●	●	●	● Thermometers
Rhode Island	●	●	●	-
South Carolina	●	●	●	-
South Dakota	●	●	●	-
Tennessee	-	-	-	-
Texas	-	-	-	O Thermometers, female condom
Utah	-	-	-	-
Vermont	-	●	●	● Thermometers
Virginia	●	●	●	-
Washington	●	●	O	-
West Virginia	●	●	●	-
Wisconsin	O	O	O	O Thermometers, female condom
Wyoming	- - -	- - -	- - -	- - -

Notes: ●=Always considered Family Planning
O=Sometimes considered family planning depending on context of visit
O=Covered, but never defined as Family Planning
- =Service not covered
- - - =States did not respond to survey
As of January 2000

Table II-5

State Medicaid Programs' Coverage of Family Planning Services: Sterilization

State	Tubal Ligation/Postpartum	Tubal Ligation/Interval*	Vasectomy
United States Total	**47**	**47**	**46**
Alabama	-	●	●
Alaska	●	●	●
Arizona	●	●	●
Arkansas	●	●	●
California	●	●	●
Colorado	●	●	O
Connecticut	●	●	●
Delaware	●	●	●
District of Columbia	●	●	●
Florida	●	●	●
Georgia	●	●	●
Hawaii	●	●	●
Idaho	●	●	-
Illinois	●	●	●
Indiana	●	●	O
Iowa	O	O	●
Kansas	●	●	●
Kentucky	O	O	O
Louisiana	●	●	●
Maine	●	●	●
Maryland	●	●	●
Massachusetts	●	●	●
Michigan	●	O	●
Minnesota	●	●	●
Mississippi	---	---	---
Missouri	●	●	●
Montana	●	●	●
Nebraska	●	●	●
Nevada	●	●	●
New Hampshire	●	●	●
New Jersey	●	●	●
New Mexico	---	---	---
New York	●	●	●
North Carolina	●	●	●
North Dakota	●	●	●
Ohio	●	●	●
Oklahoma	●	●	●
Oregon	●	-	●
Pennsylvania	●	●	●
Rhode Island	●	●	●
South Carolina	●	●	●
South Dakota	●	●	-
Tennessee	●	●	●
Texas	O	O	O
Utah	●	●	●
Vermont	●	●	●
Virginia	●	●	●
Washington	●	●	●
West Virginia	O	O	O
Wisconsin	O	O	O
Wyoming	---	---	---

Notes: ●=Always considered Family Planning
O=Sometimes considered family planning depending on context of visit
O=Covered, but never defined as Family Planning
- =Service not covered
--- =States did not respond to survey
*Tubal ligation performed separately from delivery or other surgery.
As of January 2000

so for postpartum tubal ligations, and 39 states and DC do so for vasectomies. Five states (Iowa, Kentucky, Michigan, Texas, and Wisconsin) classify interval tubal ligations as family planning in certain circumstances, as do four states (Iowa, Kentucky, Texas, and Wisconsin) in the postpartum period, and five (Colorado, Indiana, Kentucky, Texas, and Wisconsin) for vasectomy.

- **Screening and treatment** (Tables II-6 and II-7). Testing for cervical cancer, sexually transmitted diseases, and HIV are reproductive health services that, while not directly related to contraception, are intimately involved in fertility and overall health and are covered by nearly all state Medicaid programs. Pap smears are covered by 44 states and DC; and their accompanying lab services are covered by 45 states and DC. Florida and North Carolina cover lab services (but not the clinical test) while Kansas covers the clinical test but not the lab fee. Only Utah covers neither. Colposcopy services, provided as follow up on abnormal Pap tests, are covered by 39 states and DC.

  Similarly, most states cover the tests and lab services associated with screening for sexually transmitted diseases, along with treatment services. Forty-four states and DC reported covering clinical tests for STDs and 46 states and DC cover their associated lab services. Again, Florida and North Carolina cover the lab fee but not the clinical test, and Utah covers neither. All but five states (Arizona, Arkansas, Maryland, Michigan, and Utah) also cover STD treatment, and all but four (Louisiana, Maryland, Michigan, and Utah) also cover screening for HIV.

  Like exams and counseling, testing and treatment services are often classified as family planning only in certain circumstances. Only nine states consider STD tests and lab services to be family planning services in all cases, but 26 states will classify STD tests and 27 states will classify STD lab services this way if provided during a family planning visit.

- **Conception and infertility** (Table II-8). In contrast to services that prevent conception, relatively few state Medicaid programs cover services intended to promote childbearing. A preconception visit, in which a woman who is planning to get pregnant can discuss risk factors and ways to promote a healthy pregnancy, is covered as a distinct service by only 22 states and DC, although other states indicated that this service could be provided as part of a general family planning office visit. Infertility testing is covered by nine states and DC, generally limited to a Level 1 service, which consists of an initial infertility interview, education, exam, appropriate lab tests, STD counseling, and referral. Infertility treatment is covered by only three states (Colorado, Kentucky, and Minnesota) and DC. Only Colorado, New Jersey and DC cover the reversal of vasectomy under their Medicaid programs.

Thus, it appears that state Medicaid programs' coverage of family planning services is focused primarily on clinical and pharmaceutical services to prevent pregnancy and to screen for and treat reproductive health conditions. Much less commonly covered are services intended to promote conception or to assure healthy pregnancies. In addition, many states may not be taking full advantage of the opportunity to receive the enhanced Federal matching rate for family

Table II-6

State Medicaid Programs' Coverage of Family Planning Services: Cancer Screening and Follow-up

State	Pap Smear	Pap-lab	Colposcopy
United States Total	**45**	**46**	**40**
Alabama	⊙	⊙	○
Alaska	⊙	⊙	⊙
Arizona	●	●	○
Arkansas	●	●	-
California	⊙	⊙	⊙
Colorado	⊙	⊙	●
Connecticut	○	○	○
Delaware	○	○	○
District of Columbia	○	○	○
Florida	-	⊙	⊙
Georgia	⊙	⊙	⊙
Hawaii	⊙	⊙	⊙
Idaho	○	○	-
Illinois	⊙	⊙	⊙
Indiana	⊙	⊙	○
Iowa	⊙	⊙	-
Kansas	⊙	-	○
Kentucky	⊙	⊙	⊙
Louisiana	●	●	-
Maine	○	○	○
Maryland	⊙	⊙	-
Massachusetts	⊙	⊙	⊙
Michigan	⊙	⊙	⊙
Minnesota	⊙	⊙	○
Mississippi	- - -	- - -	- - -
Missouri	⊙	⊙	⊙
Montana	●	●	●
Nebraska	⊙	⊙	○
Nevada	⊙	⊙	⊙
New Hampshire	●	●	○
New Jersey	⊙	⊙	⊙
New Mexico	- - -	- - -	- - -
New York	⊙	⊙	⊙
North Carolina	-	⊙	⊙
North Dakota	●	●	●
Ohio	●	●	○
Oklahoma	●	●	●
Oregon	●	●	○
Pennsylvania	●	●	●
Rhode Island	●	●	●
South Carolina	●	●	-
South Dakota	●	●	○
Tennessee	●	●	●
Texas	⊙	⊙	-
Utah	-	-	-
Vermont	⊙	⊙	⊙
Virginia	⊙	⊙	⊙
Washington	●	●	○
West Virginia	○	○	○
Wisconsin	⊙	⊙	⊙
Wyoming	- - -	- - -	- - -

Notes: ●=Always considered Family Planning
⊙=Sometimes considered family planning depending on context of visit
○=Covered, but never defined as Family Planning
- =Service not covered
- - - =States did not respond to survey
As of January 2000

Table II-7

State Medicaid Programs' Coverage of Family Planning Services: Testing, Follow-up, and Treatment

State	STD Tests	STD - Lab	STD Treatment	HIV Test
United States Total	**45**	**47**	**43**	**44**
Alabama	◎	◎	○	●
Alaska	◎	◎	◎	◎
Arizona	○	○	-	●
Arkansas	◎	◎	-	◎
California	◎	◎	◎	◎
Colorado	◎	◎	●	●
Connecticut	○	○	○	○
Delaware	◎	◎	◎	◎
District of Columbia	○	○	○	○
Florida	-	◎	◎	◎
Georgia	◎	◎	◎	◎
Hawaii	◎	◎	◎	◎
Idaho	○	○	○	○
Illinois	◎	◎	◎	◎
Indiana	◎	◎	◎	◎
Iowa	◎	◎	◎	◎
Kansas	◎	◎	◎	◎
Kentucky	◎	◎	◎	◎
Louisiana	◎	◎	○	-
Maine	○	○	○	○
Maryland	◎	◎	-	-
Massachusetts	◎	◎	◎	●
Michigan	◎	○	-	-
Minnesota	●	●	○	●
Mississippi	- - -	- - -	- - -	- - -
Missouri	○	○	○	○
Montana	●	●	●	●
Nebraska	◎	◎	◎	◎
Nevada	◎	◎	◎	◎
New Hampshire	●	●	●	◎
New Jersey	◎	◎	◎	◎
New Mexico	- - -	- - -	- - -	- - -
New York	◎	◎	◎	◎
North Carolina	-	◎	◎	◎
North Dakota	●	●	●	●
Ohio	○	○	○	○
Oklahoma	●	●	●	●
Oregon	◎	◎	○	○
Pennsylvania	●	●	●	●
Rhode Island	●	●	●	●
South Carolina	●	●	○	○
South Dakota	○	○	○	○
Tennessee	●	●	●	●
Texas	◎	◎	◎	◎
Utah	-	-	-	-
Vermont	◎	◎	◎	◎
Virginia	◎	◎	◎	◎
Washington	○	○	○	○
West Virginia	○	○	○	○
Wisconsin	◎	◎	◎	◎
Wyoming	- - -	- - -	- - -	- - -

Notes: ●=Always considered Family Planning
◎=Sometimes considered family planning depending on context of visit
○=Covered, but never defined as Family Planning
- =Service not covered
- - - =States did not respond to survey
As of January 2000

Table II-8

State Medicaid Programs' Coverage of Family Planning Services: Infertility and Conception

State	Preconception Counseling	Infertility Test	Infertility Treatment	Vasectomy Reversal
United States Total	**23**	**10**	**4**	**3**
Alabama	-	-	-	-
Alaska	-	-	-	-
Arizona	-	-	-	-
Arkansas	●	●	-	-
California	⊙	●	-	-
Colorado	⊙	⊙	⊙	⊙
Connecticut	-	-	-	-
Delaware	-	-	-	-
District of Columbia	○	○	○	○
Florida	-	-	-	-
Georgia	-	-	-	-
Hawaii	⊙	-	-	-
Idaho	●	-	-	-
Illinois	-	-	-	-
Indiana	-	-	-	-
Iowa	-	●	-	-
Kansas	-	-	-	-
Kentucky	⊙	⊙	⊙	-
Louisiana	⊙	-	-	-
Maine	⊙	-	-	-
Maryland	-	-	-	-
Massachusetts	-	-	-	-
Michigan	●	●	-	-
Minnesota	●	●	●(limited)*	-
Mississippi	-	-	-	-
Missouri	○	-	-	-
Montana	-	-	-	-
Nebraska	-	-	-	-
Nevada	●	-	-	-
New Hampshire	●	-	-	-
New Jersey	-	-	-	○
New Mexico				
New York	⊙	-	-	-
North Carolina	-	-	-	-
North Dakota	●	-	-	-
Ohio	○	-	-	-
Oklahoma	○	-	-	-
Oregon	-	-	-	-
Pennsylvania	○	-	-	-
Rhode Island	-	-	-	-
South Carolina	-	-	-	-
South Dakota	-	-	-	-
Tennessee	○	○	-	-
Texas	⊙	-	-	-
Utah	-	-	-	-
Vermont	-	-	-	-
Virginia	-	●	-	-
Washington	⊙	-	-	-
West Virginia	-	-	-	-
Wisconsin	⊙			
Wyoming				

Notes: ●=Always considered Family Planning
⊙=Sometimes considered family planning depending on context of visit
○=Covered, but never defined as Family Planning
- =Service not covered
- - - =States did not respond to survey
*Medical procedures to correct fertility problems (such as surgery for blocked fallopian tube) only; in vitro fertilization, fertility enhancement, and artificial insemination not covered.
As of January 2000

planning services, as many states do not cover all of the services that may be classified as family planning.

B. Services Provided by Public Health Family Planning Programs for Low-Income Women

Another definition of "family planning" is that used by the public health programs that serve low-income underserved populations. In addition to Medicaid, there are other Federal sources of funding available to help low-income women obtain reproductive health services. These programs may be funded through a variety of sources, including the Title X Family Planning Program, the Title V Maternal and Child Health Block Grant, the Title XX Social Services Block Grant, or state funds. These programs often supplement Medicaid for ineligible women or are used to cover services that Medicaid does not.

- **Title X.** Established in 1970 by Congress as Title X of the Public Health Service Act, the National Family Planning Program provides funding for comprehensive family planning services through a categorical grant program. The Title X program funds a network of 4,600 family planning clinics which provided services to an estimated 5 million low-income women and men in 1999 (Office of Family Planning, 2000).
- **Title V.** The Maternal and Child Health Block Grant (Title V of the Social Security Act) has, since 1968, required states to spend 6 percent of Federal allocations to the states on family planning services (Gold and Sonfield, 1999a). This is the second largest source of public health funds for family planning services to low-income women and men.
- **Title XX.** The Social Services Block Grant (Title XX of the Social Security Act) is allocated to state social service agencies, which have broad discretion over the use of the funds. States design their own programs that are aimed at preventing, eliminating, or reducing dependence on government aid and promoting self-sufficiency. Family planning is the only medical service specified in the statute. Although states are not required to fund family planning services, Title XX has traditionally been an important source of family planning services in some states (Gold and Sonfield, 1999b).
- **State Funds.** Finally, many states use their general funds to support family planning services.

These funding sources support services provided by a range of types of providers, including free-standing family planning clinics (such as those operated by Planned Parenthood and other voluntary agencies), local health departments, community health centers, and hospital-based clinics. These providers, and the state and federal programs that make up their main funding sources, often see their role as that of a provider of comprehensive reproductive health care, primarily for women. Their services emphasize counseling and health education, while also offering the medical procedures and supplies involved in contraceptive and general reproductive health services. (See Appendix Tables A-1 through A-3). Specifically:

- **Exams and counseling services.** In contrast to Medicaid, all responding states but one (South Dakota) reported that their Title X-funded programs provide

gynecological exams, contraceptive counseling, and/or reproductive health education. In addition, more than half of responding states also devote Title V and state funds to these services, and ten states use Title XX funds for exams and counseling.

- **Prescription contraception.** All states report using public health funds to cover the medical procedures and supplies required for prescription contraceptive methods. All states use Title X funds to support the insertion and removal of IUDs and implants, and all but Pennsylvania cover injections and diaphragm fittings with Title X funds. In addition, many states use other sources of public health funds to support these services: 27 states use Title V funds to support at least one of these procedures, nine states (Alabama, Connecticut, Illinois, Kentucky, New Hampshire, New Jersey, Pennsylvania, Texas, and Vermont) use Title XX funds for this purpose, and 33 states use state family planning funds for at least some of these services.

  States are also more likely to use public health funds, particularly Title X funds, to support emergency contraception: all but four states (Alabama, Arkansas, Pennsylvania, and South Dakota) pay for this service with Title X funds. Many of these states use other funds for this service as well, 21 drawing on Title V, six on Title XX, and 29 on state funds.

  States' support for prescription family planning supplies is similar. With their Title X grants, all states but Maryland pay for oral contraceptives, implants, and IUDs; all but Maryland and Pennsylvania pay for injectables; and all but Maryland and Arkansas pay for diaphragms and Hawaii reported covering cervical caps. At least some of these supplies are covered using Title V funds in 28 states, by Title XX in the nine states listed above, and by state funds in 32 states.

- **Over-the-counter contraception.** All states report that they use Title X funds to pay for condoms and spermicide; 28 states use Title V funds for at least one of these supplies, eight (Alabama, Connecticut, Illinois, Kentucky, New Jersey, Pennsylvania, Texas, and Vermont) use Title XX, and 33 use state funds to pay for these supplies. Many states also report that they had covered sponges, and many more would do so if they were currently on the market.
- **Sterilization.** Coverage of permanent contraceptive methods with public health funds is much less common. Twenty-eight states pay for tubal ligation on an interval basis, and 23 for postpartum tubal ligation, using Title X funds, and fewer use other public health funding sources for this purpose. Similarly, vasectomy is covered by Title X in only 27 states, and while some of these states also devote other funding sources to this service, only four states (Minnesota, Oklahoma, Rhode Island, and Virginia) use state funds instead of Title X.
- **Screening and treatment.** Like examinations, counseling, and contraceptive services, Pap smears and STD testing are services commonly covered by public health family planning programs. All states but Virginia use Title X funds to pay for clinical Pap tests, and all but three (Minnesota, South Dakota, and Virginia) use Title X funds for the associated lab services. Cervical cancer screening is also covered by Title V in 27 states, Title XX in nine states (Alabama, Connecticut, Iowa, Illinois, Kentucky, New

Jersey, Pennsylvania, Texas, and Vermont), and state funds in 32 states; in nearly all cases, these sources support lab services as well.

Coverage of follow-up colposcopy services is less common, and several states report that their clinics do not always have the capacity to provide this service. Nonetheless, 26 states use Title X, 10 (Connecticut, Illinois, Indiana, Kentucky, New Hampshire, New Jersey, New York, North Carolina, Oregon, and Wisconsin) use Title V, four (Connecticut, Illinois, Kentucky, and New Jersey) use Title XX, and 20 use state funds to support colposcopies for low-income women. Several states report using grants from the CDC's National Breast and Cervical Cancer Early Detection Program for this purpose as well.

Coverage for clinical and laboratory STD testing is a common function of Title X as well. All but five states (Mississippi, Pennsylvania, Rhode Island, South Dakota, and Virginia) cover clinical STD testing with Title X funds, and all but eight (these five states and Connecticut, Hawaii, and Minnesota) cover the associated lab services. Other public health funding streams often supplement Title X for these services; for clinical services, 25 states use Title V, nine (Alabama, Connecticut, Iowa, Illinois, Kentucky, New Jersey, Oregon, Texas, and Vermont) use Title XX, and 30 use state funds, and for lab services, 20 use Title V, seven (Alabama, Iowa, Illinois, Kentucky, New Jersey, Oregon, and Texas) use Title XX, and 30 use state funds. In addition, some state programs have arrangements with state public health laboratories to process these specimens at no charge. And while HIV testing is often covered by other funding sources, it is supported by Title X in 34 states, Title V in 16 states, Title XX in four states (Iowa, Kentucky, Pennsylvania, and Vermont), and state family planning funds in 29 states.

STD treatment is covered by all but seven state Title X programs (those in Colorado, Connecticut, Mississippi, Pennsylvania, South Dakota, Tennessee, and Virginia), with supplemental funding from Title V in 19 states, Title XX in five states (Alabama, Kentucky, New Jersey, Texas, and Vermont), and state funds in 27 states.

- **Conception and infertility.** In another contrast to Medicaid coverage, public health funds were more likely to be used to support services to promote healthy pregnancies and to diagnose infertility. All but six states (Arkansas, Connecticut, New Jersey, Rhode Island, Tennessee, and West Virginia) reported that their Title X programs would provide preconception counseling. In Rhode Island (and 24 other states), this service is covered by Title V; four states (Illinois, Kentucky, Texas, and Vermont) use Title XX funds, and 27 states use state funds for this service. A basic level of infertility screening and referral is available through Title X in 23 states; of these states, 11 also support this service with Title XX funds, Connecticut and New Jersey use Title XX funds, and 15 use state funds.

  Funding for infertility treatment and vasectomy reversal is rare. Only three states (Arkansas, Utah, and Pennsylvania) provide any level of infertility treatment with Title X funds, and none use any other source of family planning funding for this purpose. Only Colorado reports paying for vasectomy reversals, using Title X and Title XX funds for this service.

These services and funding sources complement the Medicaid program in various ways, by offering a source of family planning services for low-income women who are not eligible for Medicaid and by subsidizing services that state Medicaid programs' fees do not fully cover. This will be discussed in detail in Chapter V. Family planning clinics also play a critical role in the provision of services to enrollees in Medicaid managed care programs. These programs are the subject of the next chapter.

Chapter III: Family Planning and Medicaid Managed Care

III. Family Planning and Medicaid Managed Care

Since the early 1990s, state Medicaid programs have increasingly turned to managed care programs, particularly capitated systems, to control program costs and improve access to services for their enrollees. The principal potential benefit of Medicaid managed care for its enrollees is the guarantee of a primary care provider who is responsible for managing all of her patients' care. However, managed care brings a number of specific concerns in the area of family planning. For example:

- Managed care organizations may not define "family planning" comprehensively and may not provide the full range of covered services if contract language is not specific;
- Enrollees' existing relationships with community-based providers may be disrupted, either because of referral requirements or because these providers are not included in managed care networks;
- Managed care plans may themselves be owned by faith-based organizations or may include faith-based providers who choose not to provide family planning services or referrals; and
- Enrollees' eligibility for Medicaid changes over time; for example, if their pregnancy status or asset levels change, they may cycle off the program and end up without services. Yet their needs for reproductive health services remain constant and do not decrease just because they no longer remain eligible for the program.

This chapter explores the Medicaid managed care programs in place in the states and their specific provisions for assuring access to family planning services, the payment systems that support these services, and their efforts to monitor and evaluate the quality of family planning services provided under managed care plans.

A. Medicaid Managed Care Programs

Of the 48 Medicaid programs that responded to the survey, all but Alaska reported using some type of managed care strategy to serve women of childbearing age (that is, women in families receiving cash assistance, adolescents enrolled under income-related categories for children, and pregnant women). Of these programs, 35 states and DC require enrollment in some type of managed care program, eight make enrollment voluntary, and three (Nevada, New York, and North Carolina) offer voluntary enrollment in some geographic areas and mandatory enrollment in others (Table III-1). These voluntary managed care programs tend to attract a minority of enrollees; in South Carolina, for example, only 10 percent of the state's Medicaid population enrolls in the managed care program. Similarly, capitated managed care programs are available for voluntary enrollment in two urban counties in Illinois: in Cook County, 28 percent of eligibles choose this plan, as do 16 percent in St. Clair County.

Table III-1

Medicaid Managed Care Arrangements and Payment for Family Planning

State	Managed care arrangements	Mandatory or voluntary	Family planning in capitation rate	Receive 90% match for capitated expenditures	How match is calculated
Alabama	PCCM only	Mandatory	N/A	N/A	
Alaska	None	N/A	N/A	N/A	
Arizona	Capitation only	Mandatory	●	●	Retrospectively
Arkansas	PCCM only	Mandatory	N/A	N/A	
California	Capitation only	Mandatory	●	●	Prospectively
Colorado	PCCM and capitation	Mandatory	●	O	
Connecticut	Capitation only	Mandatory	●	Not reported	
Delaware	Capitation only	Mandatory	●	●	Prospectively
District of Columbia	Capitation only	Mandatory	●	O	
Florida	PCCM and capitation	Mandatory	●	Not reported	
Georgia	PCCM and capitation^	Voluntary	●	Not reported	
Hawaii	Capitation only	Mandatory	●	Not reported	
Idaho	PCCM only	Voluntary	N/A	N/A	
Illinois	Capitation only	Voluntary	●	O	
Indiana	PCCM and capitation	Mandatory	●	O	
Iowa	PCCM and capitation^	Mandatory	●	●	Prospectively
Kansas	Capitation only	Mandatory	O	N/A	
Kentucky	Capitation only	Mandatory	●	O	
Louisiana	PCCM only	Mandatory	N/A	N/A	
Maine	PCCM and capitation^	Voluntary	●	Not reported	
Maryland	Capitation only	Mandatory	●*	●	Retrospectively
Massachusetts	PCCM and capitation	Mandatory	●	Not reported	
Michigan	Capitation only	Voluntary	●	In process	
Minnesota	Capitation only	Mandatory	●	O	
Mississippi	---	---	---	---	---
Missouri	Capitation only	Mandatory	●	O	
Montana	Capitation only	Mandatory	●	●	Prospectively
Nebraska	Capitation only	Mandatory	●	O	
Nevada	Capitation only	Varies	●	●	Retrospectively
New Hampshire	Capitation only	Voluntary	●	In process	
New Jersey	Capitation only	Mandatory	●	●	Prospectively
New Mexico	---	---	---	---	---
New York	Capitation only	Varies	●✓	Not reported	
North Carolina	PCCM and capitation^	Varies	●	●	Not reported
North Dakota	PCCM and capitation^	Voluntary	●	●	Not reported
Ohio	Capitation only	Mandatory	●	●	Retrospectively
Oklahoma	Capitation only	Mandatory	●, except teens	●	Retrospectively
Oregon	Capitation only	Mandatory	●	●	Prospectively
Pennsylvania	Capitation only	Mandatory	●	O	
Rhode Island	Capitation only	Mandatory	●	●	Retrospectively
South Carolina	Capitation only	Voluntary	O	N/A	
South Dakota	PCCM only	Mandatory	N/A	N/A	
Tennessee	Capitation only	Mandatory	●	●	Prospectively
Texas	PCCM and capitation^	Mandatory	●	O	
Utah	Capitation only	Mandatory	●✓	O	
Vermont	Capitation only	Mandatory	O	N/A	
Virginia	Capitation only	Mandatory	●*	●	Retrospectively
Washington	Capitation only	Mandatory	●**	●	Prospectively
West Virginia	PCCM and capitation^	Mandatory	●✓	●	Prospectively
Wisconsin	Capitation only	Mandatory	●	O	
Wyoming	---	---	---	---	---

Notes: ● = Yes
O = No
^ In some counties only, not a statewide choice
*Abortion is excluded from the capitation rate
**Abortion and sterilization services are excluded from the capitation rate
✓ Pharmacy services are excluded from the capitation rate
--- States did not respond to survey
PCCM = Primary Care Case Management Program
N/A = Not applicable
As of January 2000

Most state Medicaid managed care programs, including 42 who responded to the survey, provided services through capitated health maintenance organizations (HMOs) at the time of the survey. Some, however, use a primary care case management model (PCCM), in which enrollees are assigned to a primary care provider who is responsible for arranging and authorizing all covered services. These providers are generally paid on a fee-for-service basis for the direct services they provide and are paid a small fee (typically about $3) per enrolled member per month to manage their patients' care. States that use this approach exclusively include Alabama, Arkansas, Idaho, Louisiana, and South Dakota; in addition, Colorado, Florida, Indiana, and Massachusetts allow enrollees to choose between enrollment in an HMO or the PCCM program. Again, given the choice, enrollees are less likely to choose the HMO option; in Massachusetts, for example, approximately 25 percent of enrollees choose to join an HMO, as do about 33 percent in Indiana.

In order to mandate Medicaid enrollment into managed care plans, states can take one of three approaches, using section 1115 waivers, section 1915(b) waivers, or an option under section 1932 that ensures that women retain the freedom to choose their own family planning providers. Nineteen states operate their Medicaid managed care programs under section 1115(a) research and demonstration waivers, which allow states to waive a variety of statutory requirements to design innovative managed care programs. An additional 21 states and DC operate their programs under section 1915(b) waivers, which waive only the section of the Federal Medicaid statute guaranteeing free choice of providers. Six states do not currently have a waiver, either because their programs are voluntary or because they have taken advantage of the option included in the Balanced Budget Act of 1997 that allows states to enroll non-disabled Medicaid enrollees in managed care without a waiver.

B. Services Covered Under Medicaid Managed Care

Under capitated systems, the services available to enrollees are governed by the contracts between the managed care plans and the state Medicaid agency. The language in these contracts describing the family planning services to be provided by the plans varies in the degree of specificity with which they describe "family planning" services. Some are quite general, requiring only that plans provide these services. These states include Georgia, Indiana, Kentucky, Missouri, and Vermont. This general contract language appears to allow plans considerable leeway in determining exactly which family planning services they will provide.[1]

Other contracts offer definitions of family planning that are narrowly focused on contraception and do not encompass the range of screening, treatment, counseling, and other reproductive health services that fall under many state Medicaid programs' definitions of family planning. For example:

- Arizona's contract defines family planning as "including drugs, supplies, devices, and surgical procedures provided to delay or prevent pregnancy."

[1] Quotations from contracts are taken both from the original sources and from Rosenbaum, Sara, Smith, Barbara M., and Shin, Peter, et al. Negotiating the New Heath System: A Nationwide Study of Medicaid Managed Care Contracts, Second Edition. Washington, DC: The George Washington University Center for Health Policy Research, February 1998.

- Washington State's contract requires plans to "assure that female Members of reproductive age receive counseling on contraceptive methods and, if they desire contraception, that they receive the contraceptive method of their choice."

Other states simply require that managed care plans provide all services covered by the fee-for-service Medicaid program, without providing a detailed list of those services. For example, the Illinois contract reads:

> "Within the Enrollment Area, Beneficiaries are entitled to receive and the Contractor must provide all services and benefits provided by the Illinois Department Public Aid under the Illinois Medical Assistance Program, administered under Article V of the Illinois Public Aid Code and Title XIX of the Social Security Act, to the extent applicable to Eligible Enrollees. . . The following services and benefits shall be included as Covered Services and will be provided to Beneficiaries whenever medically necessary. . .Family planning services."

New Jersey, Pennsylvania, and Wisconsin also reported that their contracts simply state that all services covered under the fee-for-service Medicaid program are covered. While this language is technically accurate, it does rely on the plans to know or to find out which specific services are covered by the state's Medicaid program.

Most states, however, report that contracted managed care plans do not have any latitude to interpret or determine which family planning or reproductive health services they will provide to their enrollees. Rather, their contracts with managed care plans provide detailed lists of family planning services. However, these lists vary in breadth as well. For example:

- Thirteen states (Arizona, Colorado, Connecticut, Florida, Illinois, Michigan, North Dakota, Nevada, New York, South Carolina, Texas, Utah, West Virginia) and DC include exams and counseling in their contracts' definitions of family planning, in addition to contraceptive services. For example, Illinois' contract covers "family planning services and supplies, including physical examination and counseling provided during the visit, annual physical examination for family planning purposes, pregnancy testing, voluntary sterilization, insertion or injection of contraceptive drugs or devices, contraceptive drugs and supplies, and related laboratory and diagnostic testing."

- Nine states (Arizona, Connecticut, Michigan, Minnesota, New York, North Dakota, South Carolina, Texas, and West Virginia) and DC also include screening and treatment for sexually transmitted diseases, often explicitly including HIV. Michigan's contract, for example, covers "any medically approved means, including diagnostic evaluation, drugs, supplies, devices, and related counseling, for the purpose of voluntarily preventing or delaying pregnancy or for the detection or treatment of sexually transmitted diseases."

- In addition to the above services, three states—Maine, Minnesota and North Dakota—include infertility testing in the definition of family planning services included in their managed care contracts, and Minnesota's contract includes some medical procedures to

treat infertility as well. Conversely, one state, New Hampshire, specifically excludes "operations, devices, drugs, and procedures for the purpose of contributing to or enhancing fertility or procreation."

- Six states (Arizona, Illinois, New York, North Dakota, Texas, and West Virginia) indicated that their contracts include pregnancy testing in the definition of family planning services.

These definitions often serve two purposes: they provide detail about the specific services the managed care organizations are required to provide, and they often define the services to which "open access" or "freedom of choice" provisions apply. This issue will be addressed in the next section.

C. Access to Care

Multiple levels of outreach and education are needed to assure women and men access to the family planning services covered under Medicaid managed care programs. First, those eligible for Medicaid must be informed of the availability of coverage. Once enrolled in a Medicaid managed care plan, enrollees need to know about their options for using family planning services. In states that have "open access," this involves informing enrollees that they can use any Medicaid-certified family planning provider, including those outside the plan's network. Finally, enrollees need to know where to find family planning services.

1. Integrating Family Planning Outreach with Medicaid and S-CHIP

Because they serve low-income women, family planning providers can be integral to a state's efforts to identify and enroll eligible women and children. Likewise, Medicaid agencies or State Children's Health Insurance Programs (S-CHIP) can be critical resources in promoting family planning to low-income populations. Collaboration between family planning providers and public insurance agencies can significantly reduce the barrier of fragmented public health and welfare services.

Representatives of state Title X grantees, and representatives of reproductive health clinics were asked about the degree to which they work with state and local health departments, Medicaid, and/or S-CHIP to coordinate outreach activities. In nearly all states, family planning clinics and providers help to identify clients potentially eligible for Medicaid, both to provide a source of comprehensive coverage for the client as well as to assure the clinic of payment for their services. In most cases, family planning clinics help to identify eligible persons through regular intake interviews. Once they are identified, clients are generally referred to the appropriate social services or health department office for Medicaid enrollment.

In addition to identifying those eligible for Medicaid through intake, public health family planning agencies collaborate in other ways with local and state Medicaid agencies to reach persons eligible for enrollment. Approaches range from direct outreach, to joint fundraising, to

staff and provider education, to development of more effective referral strategies and educational materials, as described below:

- **Direct outreach strategies** take advantage of available client contact lists to contact potential clients directly about the availability of family planning services. For example, the Delaware Department of Health staff coordinated with Medicaid to mail special invitations encouraging former Medicaid recipients to use family planning services under the state's extension waiver. Each year in Vermont, the Medicaid agency does a special mailing to TANF and Medicaid recipients about family planning services. Minnesota Medicaid mails a family planning pamphlet to clients annually. In Missouri, the State Health Department worked with the WIC program on a mailing on public health family planning for Medicaid enrollees.

- **Staff and provider education** is the emphasis of collaborative efforts in California, Illinois and New Hampshire. In California, family planning providers receive special training regarding referral of clients to Medi-Cal. A cross-training program was developed in Illinois to educate Department of Human Services staff about family planning issues, and to educate family planning staff about Medicaid eligibility. Medicaid enrollment staff in New Hampshire receive training about family planning resources and how to use and access them.

- **The development and dissemination of informational materials** is the most common form of collaborative outreach effort reported by state officials. For example, in Iowa, family planning flyers are placed in Medicaid offices, and Medicaid flyers are placed in local clinics. Arkansas' state family planning staff contribute articles on family planning and such topics as emergency contraception to the Medicaid client newsletter. In New Jersey, public health family planning staff worked with Medicaid to promote New Jersey KidCare and to distribute a brochure to Medicaid clients listing family planning providers and explaining the state's freedom of choice policy.

- **Application assistance** is an immediate form of outreach that may be offered by family planning clinics. In several states—such as Ohio, Maryland, Indiana, Hawaii, and Alaska—family planning clinics go beyond simple referral to assist clients in completing Medicaid application forms. In West Virginia, family planning services have access to a Medicaid database that allows them to identify individuals that are covered and those that may be referred to apply.

In 23 states, family planning providers assist in informing former Aid to Families with Dependent Children (AFDC) recipients of their continued eligibility for Medicaid. However, 20 states reported that there was no specific effort targeted at former AFDC recipients who may have lost their Medicaid coverage or may be eligible for Transitional Medicaid Assistance. In most states, informing former AFDC recipients about continued eligibility for Medicaid typically occurs during routine intake and/or income screening of clients attending family planning clinics. However, in several states, special initiatives go beyond general intake and referral. These include the following:

- In West Virginia, targeted mailings notifying clients that they are going to lose AFDC coverage also inform them that they are still eligible for family planning.

- In Tennessee, health department nurses conduct family assessments before their cash benefits are stopped, and inform families of continued eligibility for Medicaid.

- In Delaware, clinic staff inform clients about their two-year eligibility for TANF and help them to complete applications for continued assistance.

Compared to the number of states in which public health family planning collaborates with Medicaid, fewer states (32) reported that public health family planning representatives or reproductive health clinic staff actively promote S-CHIP programs among their adolescent clients. In 16 states, representatives stated that state-level family planning agencies and local providers do not actively promote S-CHIP among clients. The major reason reported was that because a parent's signature is required on S-CHIP application forms, active promotion of S-CHIP by family planning clinics would threaten the confidentiality of services provided to adolescents. Seven states (California, Indiana, Iowa, Missouri, Nebraska, North Dakota, and Ohio) report that they do not aggressively promote S-CHIP in their clinics for this reason.

Making brochures and information available in clinic locations is the most common way that state family planning programs promote S-CHIP, but in selected states, promotion of S-CHIP among family planning clients is more aggressive:

- In Michigan, local health departments, the main providers of family planning services, have been very involved in the statewide push to increase enrollment. Staff keep enrollment forms in clinic reception areas and talk to clients about the S-CHIP program;

- On weekends, family planning staff in Kentucky put up booths at malls and grocery stores, and have K-CHIP applications on site and at these external locations during outreach efforts; and

- Clinic patients in Delaware are screened under a process called "no wrong door" which determines potential eligibility for a number of health and social services programs. Potentially eligible clients are referred to S-CHIP or Medicaid.

2. Open Access to Family Planning Services

Once individuals are enrolled in Medicaid, they need to be informed of their options for gaining access to specific providers and services. For family planning services, Federal law requires that states assure open access to any Medicaid-certified family planning provider for covered services in those states with mandatory managed care. However, this provision may be waived under 1115(a) demonstration waivers. Under open access provisions (sometimes known as "freedom of choice" provisions), Medicaid enrollees can go to providers outside the health plan's network for family planning services without a referral.

Six states indicated that their Medicaid managed care contract or waiver did not require open access to family planning providers. Five of them—Arizona, Hawaii, Kentucky, Rhode Island, and Tennessee—have mandatory managed Medicaid programs under 1115(a) waivers, and thus are not required to provide open access. Maine's voluntary managed care program, which serves only 5 percent of the Medicaid population, does not require a referral to family planning providers, but clients may not go outside the plan for services.

Open access in most states applies to all individuals that are enrolled in Medicaid managed care, and for all family planning services covered by Medicaid in the state. In several states, there are some limited qualifications:

- **Limitations on eligible groups.** Two states limit the populations eligible for open access to family planning services. In Oklahoma, which has an 1115(a) waiver, the family planning open access requirement applies only to adolescents under 18, while those 18 and older must use a health plan provider. In Wisconsin, while any Medicaid or BadgerCare enrollee is covered by the open access provision, individuals with family incomes over 150 percent of the Federal poverty level may be subject to a cost-sharing provision if they use services outside of their managed care plan; and

- **Limitations on services.** Some states limit the family planning services that may be received from out-of-plan providers. For example, in Maryland, all services are subject to open access except for tubal ligations, for reasons relating to payment for lab and anesthesia services. In Utah and Virginia, referrals are required for sexually transmitted disease testing and treatment unless the provider is in-network.

In order for open access provisions to be effective, Medicaid enrollees must be made aware of their right to use any Medicaid-certified family planning provider, including those outside a health plan's provider network. States vary in the assignment of responsibility for informing and educating Medicaid enrollees about these provisions (Table III-2):

- **Plan responsibility.** In 16 states and DC, it is primarily the health plan's responsibility to inform enrollees of the open access provision. Most plans accomplish this by including language about open access in their member handbook. In several cases, such as in Colorado, Maryland, and Montana, the state provides a template or standard language to be included. In other cases the state reviews and/or must approve the language about open access for family planning that is included in the handbook. In New Jersey and Texas, plans are required to list family planning providers that enrollees may contact;

- **State responsibility.** Virginia was the only state that reported that the Medicaid program bears the primary responsibility for informing enrollees of open access. In Virginia, this information is included in the handbook provided to enrollees at the time of enrollment; and

- **Joint responsibility.** In 17 states, both the Medicaid program or its enrollment broker and contracted health plans play a role in informing enrollees. In Minnesota, for

Table III-2

State Approaches to Informing Medicaid Enrollees About Family Planning, in States with Family Planning Freedom of Choice

State	Responsibility for Informing Enrollees About Family Planning: Medicaid Program	Broker	Health Plans	Medicaid Reviews Information or Provides Language	Method of Informing Enrollees
United States Total	**13**	**6**	**34**		
California			✓		member handbook mailed within 7 days of enrollment
Colorado			✓	✓	member handbook
Connecticut			✓		standard recipient notice
Delaware	✓		✓		notified at enrollment, plan newsletter and member handbook
District of Columbia			✓		member handbook
Florida		✓	✓		broker counseling & member handbook
Georgia			✓	✓	plan marketing materials
Illinois			✓	✓	member handbook
Indiana		✓	✓		member handbook & plan newsletter
Iowa			✓	✓	member handbook
Kansas			✓		member booklet
Maryland	✓		✓	✓	Medicaid brochure & plan informational materials
Massachusetts	✓		✓		new member packets
Michigan		✓	✓		enrollment agency & member handbook
Minnesota	✓		✓		Medicaid family planning brochure & plan informational materials
Missouri			✓	✓	member handbook
Montana		✓	✓	✓	member handbook & enrollment broker interview
Nebraska		✓	✓		enrollment broker & member handbook
Nevada	✓		✓	✓	member handbook
New Hampshire	✓		✓	✓	plan welcome letter & enrollment information
New Jersey	✓		✓	✓	Medicaid brochure, member handbook, lists family planning providers
New York	✓		✓	✓	member handbook, state public education campaign
North Carolina	✓		✓	✓	plan information, state Medicaid handbook
North Dakota			✓	✓	member handbook
Ohio			✓		member handbook, periodic home visits
Oklahoma			✓	✓	member handbook
Pennsylvania			✓		member handbook
South Carolina	✓		✓	✓	plan information, state Medicaid handbook
Texas	✓		✓		member handbook, list of family planning providers, eligibility letter
Utah			✓		plan orientation with new members
Vermont			✓		
Virginia	✓				Medicaid enrollment brochure
Washington	✓		✓	✓	member handbook
West Virginia		✓	✓		information mailed to enrollees
Wisconsin			✓	✓	handbook

Notes: Oregon was unable to provide information on these questions.
As of January 2000

example, health plans are required to inform new enrollees of open access to family planning at the time of enrollment. In addition, the Medicaid program mails a brochure on family planning to enrollees. In Indiana, the state's enrollment broker provides this information at the time of enrollment and open access is further addressed in a Medicaid newsletter for enrollees. Indiana Medicaid MCOs are required to address open access in member handbooks. Additionally, primary care providers are counseled to share this information with clients.

Despite these provisions for informing enrollees about open access, state public health officials and reproductive health agency representatives in most states did not feel that enrollees fully

understand their right to open access to family planning. Provisions for outreach to and education of Medicaid enrollees with respect to family planning were not viewed as consistently effective, for a range of reasons:

- **Inadequacy of efforts to inform enrollees.** Public health officials in nine states (Colorado, Massachusetts, New Mexico, North Carolina, North Dakota, Ohio, South Dakota, Texas, and Vermont) reported that their state Medicaid agencies as well as managed care plans did not give clear, consistent, and thorough information to enrollees about their right to open access. For example, they reported that the language describing the policy was weak, and did not give a clear definition of the services covered under the policy (in Massachusetts); that the quality of information varied depending on the plan and the relationship between the plans and the local health departments (in North and South Dakota); and that no system existed to assure that plans were providing the information (in Texas);

- **Financial disincentives to inform and refer.** Public health officials in seven states (Illinois, Massachusetts, Missouri, New Jersey, North Carolina, Oklahoma, and Wisconsin) felt that plans and state Medicaid agencies do not give information about access to out-of-plan providers because it is not in their financial interest to do so. In one state in which the Medicaid agency is responsible for informing enrollees about open access, public health officials reported that "the state discourages HMO enrollees from using family planning [clinics] because it costs them more . . . it doesn't come out of the HMO payment." In another state in which the plan has this responsibility, a similar charge was heard: " The plan fears that if it promotes the use of family planning clinics by their clients, the state will accuse them of dumping their clients and cost shifting, since the clinics bill Medicaid for family planning service delivered through the open access provision";

- **Confusion among providers, plan, or program staff.** Public health officials in five states (Arkansas, New Hampshire, North Carolina, Oklahoma, and Oregon) reported that providers and plans did not fully understand the open access provision and its importance for clients. In one state, for example, an official felt that open access was confusing because family planning was the only service to which the policy applied, and when people called their plans to inquire about it, they were told to call their primary care provider; and

- **The complexity and volume of information that Medicaid enrollees receive.** Public health officials in Nevada and Texas noted that Medicaid managed care enrollees are overwhelmed with information. While notices about the open access provision may be included in member handbooks, it is likely to be missed.

Most Medicaid and public health officials acknowledged the importance of open access provisions for assuring that family planning services are accessible to low-income women and men. However, several also acknowledged the tensions that these policies create. On one hand, these policies help to assure confidentiality of services, which may be important to adolescents or those seeking testing and treatment for STDs; however, this very feature may undermine the coordination of care, as primary care providers will not have information about the full range of

their patients' health care needs. Similarly, the option to use out-of-plan family planning clinics may provide access to a more comprehensive set of family planning services from a familiar provider in the client's community; however, this benefit may conflict with the major potential advantage of managed care, the ability to receive all primary care services through a single medical home. To address these dilemmas, some state and clinic officials recommended that family planning providers become more aggressive about joining managed care networks, so as to make their services accessible to the plans' members while allowing better communication and coordination with primary care providers, when appropriate.

3. Faith-Based Plans and Providers

A discussion of Medicaid clients' access to family planning services under managed care arrangements would not be complete without addressing the issues that arise when Medicaid managed care plans refuse to provide certain types of family planning services on the basis of religious or moral grounds. While the potential barrier to receipt of family planning services when institutions and/or individual providers refuse to provide them is certainly not limited to Medicaid clients, the issue is particularly salient for Medicaid recipients because of their unique entitlement under federal law to family planning services.

Concern about Medicaid managed care enrollees' access to family planning services was heightened by Congress' passage of the Balanced Budget Act of 1997 (BBA). While prohibiting Medicaid managed care organizations from establishing restrictions that interfere with enrollee-provider communications, the BBA also allowed Medicaid managed care plans to refuse "to provide, reimburse for, or provide coverage of counseling or referral services for specific services, if the [plan] objects to the service on moral or religious grounds. In these cases, the states remain responsible for assuring access to all covered services" (HCFA, 1998). While "conscience clauses" have always permitted individual providers to refuse to provide services that they found objectionable, this provision extended that protection to corporate entities for the first time.

In light of this provision, HSR explored the degree to which state Medicaid agencies have contracted with these so-called "faith-based" plans. The survey found that seven states contract directly with faith-based plans, typically Catholic health systems, that do not provide one or more types of family planning services. These states include: Illinois, Missouri, New York, Pennsylvania, South Carolina, Washington, and Wisconsin (Table III-3). However, the influence of these plans on access to family planning services varies. In four states (Illinois, New York, South Carolina, and Washington), the faith-based plans do not provide specific services. In the other three (Missouri, Pennsylvania, and Wisconsin), the plans are required to make all contracted services available to their enrollees; therefore, subcontractors or other agencies are hired to provide these services. In the case of Pennsylvania's plan, another managed care plan performs this function as a subcontractor; in Missouri, a third-party administrator was hired to handle all matters related to family planning, including claims processing. In Wisconsin, the state contracts with a plan that is partially owned by the Catholic Diocese, but other contracted providers in the plan's network provide certain family planning services.

Table III-3

State Medicaid Arrangements with Faith-Based Plans

State	Services Excluded From Contract	How Enrollees are Informed		Strategies for Assuring Access to Family Planning Services	Payment of Contracted Plan	
		Member Handbook/Plan Materials	Letter		Standard Capitation	Adjusted Capitation
Illinois	Contraceptive visits, counseling, procedures, and supplies; laparoscopy; tubal ligation; vasectomy; abortion	✓		Clients can access FP services through Medicaid fee-for-service (FFS) providers; plan required to refer to other providers.		✓
Missouri	None. Plan must provide all family planning services through network	✓		Plan contracts with third-party administrator to handle all FP services and payments.	✓	
New York	Birth control, and/or sterilization (varies by plan); abortion	✓	✓	Clients can access FP services through Medicaid fee-for-service (FFS) providers		✓
Pennsylvania	None. Plan must provide all family planning services through network	✓		Plan contracts with another licensed HMO to provide FP services	✓	
South Carolina	All services (including counseling), procedures, devices, and medications for the purpose of infertility treatment or for preventing or terminating pregnancy including temporary or permanent sterilization procedures (e.g., tubal	✓	✓	Clients can access FP Services through Medicaid FFS providers.		✓
Washington	sterilizations	✓		Primary care provider refers to non-faith based provider	✓	
Wisconsin	None. Tubal ligations not provided by one provider (part owner of plan) but plan must provide through other network providers	✓		Client referred to a non-faith based provider	✓	

Notes: As of January 2000

While only seven states reported having contracts between the Medicaid agency and faith-based plans (and states consistently indicated that the number of enrollees in these plans is quite small), the issue of faith-based providers' influence on access to family planning is clearly an issue in many more states. The Medicaid representatives in numerous states, including California, Colorado, Connecticut, Delaware, Indiana, Maryland, New Jersey, and Oklahoma, indicated that the plans with which they contract include faith-based providers in their networks.

In addition, even in states where Medicaid representatives did not indicate that contracted Medicaid plans' networks include faith-based providers, public health department representatives interviewed frequently noted that certain providers, particularly Catholic hospitals, do not offer certain types of family planning services. Thus, the number of people affected by the policies of faith-based providers is likely to be significantly greater than indicated by the small enrollment of Medicaid clients in the eight states that contract directly with faith-based plans. For example, in New Jersey, Mercy Health Plan, a faith-based plan, is a subcontractor to a Blue Cross plan in one county. New Jersey Medicaid officials noted that 25 to 30 percent of Medicaid managed care enrollees in the county are affected by Mercy's lack of coverage for contraceptive and sterilization services. Despite the potentially large number of people affected by the participation of faith-based providers in Medicaid managed care networks, Medicaid officials were in some cases not well informed regarding the arrangements that their contractors have made with faith-based providers, a reflection of the fact that state Medicaid agencies generally do not closely monitor the arrangements made between contractors and the providers in their networks.

Faith-based plans with which the Medicaid agencies have directly contracted typically do not provide contraception, abortion, and/or sterilization services, with variations occurring across states as well as within states by plan. For example, in Washington and Wisconsin, Medicaid representatives indicated that sterilization services were the only type of service affected, whereas in Illinois, in cooperation with the Catholic diocese, the contractor has identified a broad range of services that the plan will not cover. These include physical exams and counseling for family planning; contraceptive management including insertion or removal of implantable contraceptive capsules and insertion or removal of IUDs, diaphragms, or cervical caps; abortion including in the circumstances or rape, incest, or due to health of the mother or to save the life of the mother; laparoscopy; tubal ligations; and vasectomy.

Informing Enrollees. The study also explored how states ensure that enrollees in faith-based plans are informed of the family planning coverage policies of their plan. For states that contract directly with plans that do not provide the full range of Medicaid services on religious or moral grounds, HCFA (1998) has clarified that the plan must make information on its policies available to prospective enrollees in writing before or during enrollment and must provide written notification to enrollees within 90 days of the change. This mandate is carried out by states' requirements that plans provide information in the member handbook on service coverage policies and how members may obtain family planning services. The Medicaid agency typically reviews the wording of these statements to ensure that the text meets the state's informing requirements.

To meet HCFA's requirement that states assure that enrollees in faith-based plans have access to family planning services, Medicaid representatives typically indicated that they rely on the open access provision to ensure enrollees' access to family planning services. That is, enrollees in faith-based plans, like enrollees in other Medicaid managed care plans, may seek family planning services from Medicaid providers that are not in their plans' networks. In some cases, as noted in New York, the plan's provider may deliver the family planning services, not in his or her capacity as a participating provider in the plan, but as an independent Medicaid provider in the community. Texas relies specifically on the county public hospital clinics to fill this need.

While Medicaid representatives indicated that plans generally will give referrals to other providers for family planning services which they do not provide, they did not necessarily indicate that clients receive a list of family planning providers as a matter of course. An exception to this was New York—of the states identified as having contracts with faith-based plans, it is among the most explicit regarding its requirements for informing patients of their policies and how they may receive family planning services. The state has written guidance for plans:

- that do not provide family planning services to specify that the contractor will inform prospective enrollees, new enrollees, and current enrollees that certain family planning and reproductive health services are not covered by the contractor;
- that such services may be obtained through other Medicaid providers; and
- that no referral is needed nor is there any cost to the enrollee for such services.

The guidance also notes that this information will be provided through the contractor's written marketing materials, including the member handbook, as well as orally at the time of the enrollment and at any time an inquiry is made regarding family planning and reproductive health services. If contacted by prospective and current enrollees, the contractor is required by the state to mail a letter explaining the enrollee's right to receive the non-covered services as well as an approved list of family planning providers who participate in Medicaid in the enrollee's community within 48 hours of the inquiry.

In short, states rely heavily on the open access provision for family planning services to assure that enrollees in faith-based plans have access to these services. Medicaid providers who render family planning services to these enrollees are typically paid by the Medicaid agency on a fee-for-service basis. Interestingly, only three states—Illinois, New York, and South Carolina—indicated that they adjust the capitation rates paid to faith-based plans to compensate the state for the fee-for-service payments it must make to independent providers to deliver family planning services. In these cases, the states remove the portion of the capitation rate that is estimated for family planning services from the plan's rate.

However, in three states, Missouri, Pennsylvania, and Wisconsin, the faith-based plans must pay family planning providers out of their capitation rates. Missouri, for example, is responsible for payment of services rendered by its third-party administrator for family planning services. The remaining state, Washington, pays faith-based managed care plans the same capitation rate paid to other managed care plans despite the fact that they are not responsible for providing the same scope of services. In this case, however, only sterilization services are affected, so the associated costs are likely to have been considered small enough to not warrant an adjustment of the rates.

D. Payment

In addition to changing the way enrollees gain access to care, managed care also changes the way providers are paid for services. In the case of family planning services, provider payment takes place on two levels: managed care plans are paid by state Medicaid agencies for the family planning services they offer, and out-of-plan providers are paid for serving patients who exercise

their "freedom of choice" option to receive services outside the managed care networks. This section discusses these payment systems in detail.

1. Inclusion of Family Planning Services in Capitated Payments

Thirty-eight states and DC reported that family planning services were included in the capitation rates paid to managed care organizations under their Medicaid managed care systems (Table III-1). Three states (Kansas, South Carolina, and Vermont) reported that family planning was completely carved out of capitated payments; that is, plans and other providers are paid on a fee-for-service basis for all family planning services they provide. Other states exclude specific subsets of services or enrollees from their capitation rates:

- New York, Utah, and West Virginia carve out of their rate all pharmacy services, including prescription contraceptive supplies, allowing any willing pharmacy to bill Medicaid for services; and

- Oklahoma provides all family planning services to adolescents on a fee-for-service basis, regardless of provider.

When family planning is included in capitation rates, it becomes more complex for states to claim the 90 percent Federal matching rate for these services. Under a fee-for-service system, these claims are based on the actual amount billed by providers for qualifying services; under capitation, plans are paid per enrolled member, not per claim, so the actual amount paid for family planning services may not be known. For this reason, 11 states and DC reported that they are not able to claim the 90 percent match for family planning services provided under their capitated systems, and officials in seven additional states were unsure whether or how the enhanced rate was being claimed. However, 18 states reported that they claim the 90 percent match (and two said they were developing a method of doing so), using two main strategies:

- **Prospectively.** One approach, used by nine states, is to estimate the proportion of the capitation rate that is accounted for by family planning services. That is, since capitation rates are often developed based on historical Medicaid utilization data, it is possible to identify family planning claims within those databases and calculate the proportion of the total rate that these expenditures represent. The 90 percent match can then be claimed for this proportion of the capitation payments for enrollees in the relevant eligibility categories or demographic groups.

- **Retrospectively.** Seven states reported that they receive encounter data from managed care plans that allow them to determine the number and type of family planning services provided by the plans after the fact. These encounters can then be associated with standard Medicaid reimbursement rates to claim the 90 percent match.

According to HCFA guidance, the prospective method—calculating the estimated expenditure based on actuarial data—is acceptable, as long as the estimate takes into account the amount of family planning services provided by out-of-network providers and paid outside of capitation rates.

2. Payment of Out-of-Plan Providers

Thirty-six states' capitated Medicaid managed care programs require that people enrolled in Medicaid have "open access" to traditional community-based family planning providers. This provision requires that states have a mechanism in place for paying providers who are not in managed care organizations' networks for the services they provide to the plans' enrollees. Two approaches are used:

- 19 states and DC require that the plans reimburse family planning providers for their services, whether or not they are contracted members of their provider networks. In these cases, reimbursement rates may be negotiated individually between the plans and the providers (as is the case in 13 states). Some of these states, like Maryland and Missouri, require that rates be no lower than Medicaid rates, while Connecticut and North Carolina require that these rates be no higher than Medicaid's. Alternatively, states may simply require that plans use Medicaid reimbursement rates to pay out-of-network providers (as do California, Georgia, Indiana, Michigan, Texas, West Virginia, and DC).

  States may also require that payments be made to these providers within a specific amount of time. For example, five states (Maryland, Minnesota, Georgia, Texas, and Wisconsin) require that family planning claims be paid within 30 days, and five others (Arizona, Michigan, North Carolina, North Dakota, and Nevada) require, following HCFA guidance, that 90 percent of claims be paid within 30 days and 99 percent be paid within 90 days. Other states simply require that these payments be within a "reasonable" time period or be made on a "timely" basis. However, clinics in four of these states (Delaware, Florida, Ohio, and Texas) report that timely payment can be a problem when billing managed care organizations.
- The other potential payment mechanism is to have out-of-plan providers bill the state Medicaid agency for family planning services, as is the policy in 16 of the responding states. Under this scenario, however, the state could end up paying for these services twice, by including the anticipated cost of family planning services in capitation rates paid to plans and then paying out-of-plan providers separately. Therefore, some states use reconciliation processes to reimburse the state for these expenditures. For example, New York officials reported that the state bills the plans for claims they pay to out-of-plan providers. Similarly, Massachusetts reported that they conduct a year-end reconciliation process to reclaim these funds from the plans. In contrast, officials in four other states (Colorado, New Hampshire, New Jersey, and Oregon) reported that they have not made an effort to recoup funds paid to out-of-plan providers (although one was considering requiring these providers to bill the managed care plans to avoid the problem of double payment). In one state, Medicaid officials explained that they did not want to appear to penalize plans if their enrollees sought family planning services outside of their networks.

Clinics in five of the states that bill Medicaid directly for out-of-plan services report frequent problems being paid under these systems. Clinic associations in Iowa and Illinois report the main problem to be delays in payment, while those in Colorado, New Hampshire, and Utah

report frequent denials of services. In New Hampshire, for example, clinic representatives explain that the state's direct access policy only encompasses one visit per year and one follow-up visit without a referral; therefore, they often write off bills they believe should be covered under the state's definition of family planning.

E. Quality Assurance and Monitoring

As states shift Medicaid services into managed care systems, they gain the ability and the responsibility to more closely monitor the services provided. The potential benefits of cost containment and efficiency which make managed care desirable on one hand, have on the other hand created concerns over whether such efficiency is bought at the price of quality. However, despite the increased attention aimed at quality assurance, there remains in many service areas, including family planning services, a dearth of information regarding the effect of managed care systems on the quality of care clients are receiving.

The lack of information on quality is not surprising given that no standard definitions or measures of the quality of family planning services currently exist. Objective measures and questions that would allow states to monitor the quality of family planning services are absent even from the national monitoring systems such as the Health Plan Employer Data and Information Set (HEDIS) and the Consumer Assessment of Health Plans Survey (CAHPS), which states rely upon to support their quality monitoring activities. Thus, national information about the use of family planning services in managed care plans or clients' satisfaction with these services is not available.

One potential and measurable indicator of the quality of family planning services under Medicaid managed care programs is client satisfaction, which may be reflected in where enrollees choose to go for health care services and the reasons for their choices. This is particularly relevant in states that allow managed care enrollees free access to out-of-plan providers: determining the proportion of Medicaid clients who choose to receive services from managed care providers and the proportion who seek services from providers outside of the managed care plans can be a key starting point in assessing the quality of family planning services under managed care. However, efforts to monitor the provision of family planning services among the 39 participating states plus DC that include family planning in their capitated Medicaid managed care programs varied (Table III-4):

- Just two states, Arizona and Delaware, indicated that they are using billing or other data to analyze Medicaid enrollees' patterns of family planning service use;

- Several states indicated that their data systems are still under development or undergoing refinement, or that they are in such early stages of data collection that this analysis has not been possible. Nine of these states (Arizona, Colorado, Massachusetts, Michigan, Montana, Nevada, Oklahoma, Texas, and Wisconsin) are planning to collect and analyze these data in the future, while two others (Illinois and Pennsylvania) were unclear whether these analyses are planned in the future; and

Table III-4.

Monitoring of Patterns of Family Planning Service Use by State Medicaid Managed Care Programs

State	Collecting Data on FP Service Use	Analyzing Patterns of FP Service Use	Plan Future Analyses of FP Service Use	Data collected but not usable*
Arizona	✓	✓	✓	
California	✓			✓
Colorado	✓**		✓	✓
Connecticut	✓			
Delaware	✓	✓		
District of Columbia				
Florida				
Georgia				
Illinois	✓**			✓
Iowa				
Indiana	✓			
Louisiana	✓			
Maine	✓			✓
Maryland	✓			✓
Massachusetts			✓	
Michigan			✓	
Minnesota				
Missouri	✓			✓
Montana	✓		✓	
Nebraska	✓			
Nevada	✓		✓	✓
New Hampshire				
New Jersey	✓			✓
New York	✓			✓
North Carolina				
North Dakota	✓			
Oklahoma	✓		✓	✓
Pennsylvania	✓**			✓
South Dakota				
Texas	✓		✓	
Utah	✓			
Virginia	✓			✓
Washington	✓			✓
West Virginia				
Wisconsin	✓		✓	

Notes: Table excludes states that carve out family planning services.
In Hawaii, Kentucky, and Rhode Island, the open access provision is waived and the states are not monitoring family planning utilization.
Ohio and Oregon were unable to provide information for this question.
*Data cannot currently be analyzed due to data quality issues.
**Data not yet available
As of January 2000

- Nearly half of the states, however, indicated that they do not collect data that would allow for this analysis and have no plans to do so in the future.

Of the states that are collecting this type of encounter data, several report data system problems that hinder data collection or analysis, while others stated that they simply do not see the need to conduct such analysis. Several states pointed out, with a measure of frustration, that they have had difficulty obtaining usable data from the plans. States such as Colorado, Oklahoma, Maine, New York, Virginia and Washington reported having problems obtaining uniform data across plans or simply obtaining usable data from the plans at all. A few states, such as Oklahoma, Virginia and Washington, indicated, however, that they are working with the plans to improve the data or attempting to refine or improve the data collection process. Two states (Indiana and North Dakota) indicated that although information on patterns of family planning service use could be obtained from the claims/encounter data, they do not see it as a real need. North Dakota does, however, interview out-of-plan providers regarding their experiences billing the plans to assess whether these providers are having difficulty obtaining payment from managed care organizations for the provision of family planning services.

Despite the lack of quantitative data with which to assess the use of out-of-plan services, qualitative information, as reported by family planning providers, may also reflect clients' perceptions of the quality of services in managed care plans. Reproductive health clinic representatives in 26 states indicated that they thought Medicaid clients preferred their services to those offered within the Medicaid managed care plans. While these reports are largely impressionistic, the major reasons they felt that Medicaid clients choose to receive family planning services from public health clinics included the following:

- **Familiarity and comfort with family planning clinics.** Client representatives in 19 states reported that their clients used their clinics prior to Medicaid enrollment, and many had family members and friends who have used the clinic for years or even generations;
- **Assurance of confidentiality.** In 17 states, clinic staff reported that their assurance of confidentiality regarding reproductive health issues was appealing to clients, especially adolescents;
- **Convenience.** Clinic representatives in 16 states reported that their clients choose family planning clinics because supplies are available on-site, clients are able to access appointments in a more timely manner, and some clinics, which are co-located with WIC and other services, offer 'one-stop-shopping' for clients;
- **Provider characteristics.** In 13 states, clients were perceived to prefer the clinic because providers tend to be female and are perceived by clients as being more knowledgeable about family planning issues than the general family practitioners from whom Medicaid clients would receive family planning services in their managed care plan; and
- **Comprehensive services.** In eight states (Alabama, Delaware, Florida, Kentucky, Missouri, Mississippi, North Carolina, and Oregon), clinic representatives felt that clients prefer their clinics because of the family planning education and informational

materials that are provided along with clinical services and the additional time that providers spend with each client.

Although these clinic attributes may account for some Medicaid managed care clients' preference for using traditional family planning providers, objective measures of the quality of family planning services have yet to be developed. Moreover, it appears that monitoring the use of family planning services within and outside managed care networks is not a priority in most states.

Chapter IV: Family Planning Waivers

IV. Family Planning Waivers

As discussed in the previous chapter, many states have implemented Medicaid research and demonstration waivers, known as section 1115(a) waivers, as a central component of their broad health care reform efforts. Through these waivers, states have expanded access to Medicaid and introduced managed care to their Medicaid systems, developments which have had important implications for the delivery of family planning services to low-income women.

In the mid-1990s, states also began to use section 1115(a) waivers for a more specific purpose: to expand Medicaid coverage for family planning services to targeted groups of persons who would otherwise not be eligible for Medicaid. These targeted Medicaid expansions offer important advantages for both family planning clients and providers. Eligible clients can now receive services free of charge where they might otherwise have had to pay sliding-scale fees, and providers receive payment for services for which they were previously uncompensated (Gold, 1999). In addition, these expansion waivers (or extension waivers, as they are also commonly called) are potentially very cost-effective for states, as the Federal government pays 90 percent of Medicaid family planning services expenditures. (Although HCFA originally intended these waivers to cover only those family planning services matched at the 90 percent rate, the agency now allows states to include services for which they receive the standard matching rate in their waiver programs as well.)

Twelve states are currently operating statewide expanded family planning programs under section 1115(a) waiver authority (Table IV-1). HCFA has approved most of these waivers for a period of 5 years, although in a few cases the waivers have been granted for shorter periods of time. South Carolina and Rhode Island, two of the first states to receive approval from HCFA to operate this type of program (in 1993 and 1994 respectively), have each received approval for a second waiver to build on their early experiences. Momentum for the use of 1115(a) waivers to expand Medicaid coverage for family planning services has significantly increased in the past few years; since 1997, seven states (Arkansas, California, Florida, Missouri, New Mexico, New York, and Oregon) received HCFA approval to initiate new family planning waiver programs.

In addition to those states currently operating programs, the study found that at least six more states are in the process of writing or have already submitted a waiver proposal to HCFA (Alabama,[2] Colorado, North Carolina, Oklahoma, Wisconsin, and Washington) and five additional states (Georgia, Iowa, Kansas, New Hampshire, and Virginia) are considering pursuing this path. However, the study found that even more states would likely pursue expanded Medicaid coverage of family planning services if it were an easier option to implement. As with comprehensive reforms using 1115(a) waiver authority, states must receive federal approval from HCFA to use waiver authority to extend family planning services.

[2] Alabama currently has a waiver operating in Mobile County only to extend family planning benefits for two years beyond the postpartum period for Medicaid eligibles. The state has applied for a waiver to expand this program statewide. This chapter will address statewide waivers only.

Table IV-1

States with Medicaid Waivers Expanding Coverage of Family Planning Services

State	HCFA Approval Date	Length of Waiver Approval
United States Total	**12**	
Arizona	July 1995	4 years (extension pending)
Arkansas	September 1997	5 years
California	December 1999*	5 years
Delaware	October 1995	5 years
Florida	August 1998	5 years
Maryland	Fall 1994	5 years (in process of getting extension)
Missouri	April 1998	5 years
New Mexico	May 1997	5 years
New York	July 1997	5 years
Oregon	October 1998	5 years
Rhode Island	1994: original waiver (extension granted in 1999)	5 years, with a 3-year extension
South Carolina	1993: original waiver 1997: second waiver (extension granted)	3 years (each waiver; extension is for 2 years)

Notes: *California's waiver replaced a previously state-funded program.
Alabama currently operates an expanded family planning program in Mobile County.
As of January 2000

In a recent article on states' use of family planning waivers, Gold (1999) highlights the barriers that the waiver process can present to states interested in expanding family planning coverage. Specifically, she notes that states that have gone through the process report that it is typically time consuming, resource intensive, and complex to get approval, and that burdensome paperwork and reporting requirements continue after approval is received. She also notes states' reports that political barriers, such as when a state's governor is of a different political party from that of the federal administration reviewing the waiver, can be enough to cause a state to forgo seeking a waiver in the first place. In 1999, the late Senator John Chafee of Rhode Island introduced a bill to allow state Medicaid programs to expand family planning services to

uninsured women without first getting a federal waiver (Ferguson and Leddy, 1999). Although the bill died in Committee in March 1999, this study provides support for a similar course of action. Numerous state Medicaid officials indicated that they would be more likely to consider expanding Medicaid coverage of family planning services if a federal waiver were not required.

A. Eligibility and Enrollment

Across the various state waivers, several models have been implemented which target different population groups (Table IV-2):

- **Extension of Medicaid eligibility beyond the postpartum period.** This model builds directly on states' existing option to extend Medicaid coverage to women who meet income eligibility guidelines for services required during pregnancy and through 60 days postpartum. Six states (Arizona, Florida, Maryland, Missouri, New York, and Rhode Island) extend Medicaid coverage for family planning services beyond this postpartum period. Five states in this category extend Medicaid coverage for these benefits for a period of two years, whereas Maryland extends coverage for five years. In addition, of the states that indicated they were in the process of applying for a family planning 1115(a) waiver, Alabama is one that is planning on extending coverage to this target population;

- **Extension of Medicaid coverage after loss of Medicaid for any reason.** One state, Delaware, has obtained federal approval to extend Medicaid coverage for family planning services to women who have lost Medicaid eligibility for any reason (except fraud). Coverage is extended for a period of two years, as long as the client's family income does not exceed 300 percent of the federal poverty level in the second year of coverage; and

- **Expansion of Medicaid coverage on the basis of income.** Five states (Arkansas, California, New Mexico, Oregon, and South Carolina) have chosen to extend Medicaid coverage for family planning services to women, or in California and Oregon's case to women and men, solely on the basis of income. This broad approach is also being pursued by at least two of the states currently pursuing HCFA approval for family planning waivers: Wisconsin has submitted a waiver to provide coverage to women up to 185 percent of poverty, and Washington is hoping to replace a state-funded program that provides family planning services to postpartum women by getting federal waiver approval to cover men and women up to 200 percent of the poverty level.

Outreach and Eligibility. The waivers' target populations influence the ease and simplicity of their eligibility and enrollment systems. For programs targeting postpartum women nearing the end of the Medicaid eligibility period, identification and enrollment can be very simple, as these women are already in the Medicaid system. In fact, all of the states extending family planning services to persons losing Medicaid coverage indicated that no additional application is required for enrollment in the waiver program. In most cases, the recipient is automatically mailed a new Medicaid card for the family planning services program.

Table IV-2

Target Populations for Family Planning Expansion Waivers

State	Length of Eligibility
After end of postpartum period:	
Arizona	2 years
Florida (185%)	2 years*
Maryland	5 years
Missouri	2 years
New York	2 years
Rhode Island	2 years
After loss of Medicaid for any reason:	
Delaware	2 years**
Based on income:	
Arkansas (133%)	No time limit
California (200%)	1 year†
New Mexico (185%)	2 years
Oregon (185%)	1 year†
South Carolina (185%)	No time limit‡

Notes: *Florida requires that eligible women have received a Medicaid-paid pregnancy-related service (including those related to "termination of pregnancy") within the past two years.

** Income must not exceed 300% of the federal poverty level in the second year to remain eligible

†California and Oregon's programs are open to women and men; recertification is available annually

‡ South Carolina is currently operating its second family planning waiver program.
The first waiver extended family planning services for 22 months to women losing Medicaid eligibility
The second waiver, and its subsequent extension, expanded the target population to include women eligible based on income alone, with no explicit time limit.

Alabama currently operates an expanded family planning program in Mobile County.

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States face a greater challenge in identifying and enrolling people in waiver programs that are income-based, especially those who have not been enrolled previously in Medicaid. In an effort to reach the people likely to be eligible for family planning waiver programs, states have generally opted to base outreach and eligibility determination efforts in provider offices where women typically seek family planning services. Many states have also taken steps to keep the application process simple. California and Oregon, along with Alabama and New York, indicated that they determine eligibility at the provider site:

- Providers of California's family planning waiver program, known as Family PACT, determine eligibility at the point of service for clients who complete a self-certification form of gross income, family size, and other sources of family planning health care coverage. If deemed eligible, the provider issues the client a card that can be used at family planning providers as well as at pharmacies and laboratories; and
- Currently, enrollment in Oregon's Family Planning Expansion Project is conducted on-site through all participating providers, primarily Title X family planning clinics, at the time of service. Clients complete a short application form including information about income, financial resources, and family size, and eligibility is immediately determined. Teens are eligible based on their own income in order to assure confidentiality and reduce barriers to service. Eligibility is site-specific, circumventing the need to issue identification cards and helping to keep administrative costs low, although if a client changes providers a new application must be submitted.

  Whether this system can continue in its current form is under review, as HCFA has asked the state to develop a plan to extend the program to private providers. Since not all private providers will have the capacity to do on-site enrollment, state officials expect that the administrative aspects of the program, including enrollment, will become more complex and costly.

States that do not have on-site enrollment have in some cases taken other steps to facilitate and expedite the eligibility process:

- New Mexico has developed a shortened application form for its waiver program that people may receive assistance in completing at public health offices and Indian Health Service facilities. Applications are forwarded to the county Income Support Division Office, which aims to process the application within three days and contact the clients by phone to inform them of the eligibility determination outcome. However, the lack of a clinic-based enrollment option is reported by state public health officials to be a major barrier to full use of the waiver program.

Some states have also worked to promote the availability of family planning services coverage through outreach and marketing efforts. Many states, including Arkansas and California, have focused most attention on facilitating outreach through their provider networks, especially in the early stages of their programs. Other states have implemented broad media-based outreach efforts. For example:

- Florida is promoting the availability of family planning services through a media campaign entitled *Two Years Apart is Baby Smart.* Conducted under contract with the University of South Florida, this campaign includes TV ads, billboards, bus placards, recipient brochures, provider materials, and an 800 number; and

- New Mexico's Department of Health, in collaboration with the state Medicaid agency, has implemented a *Say Yes to Healthier Kids* campaign, which, while comprehensive in nature, includes a special focus on the importance of family planning and the availability of services through the waiver program. Publicity has targeted both potential recipients and providers through such means as local news segments, billboards, posters in English and Spanish, and mailings to family planning providers.

In addition, Oregon has conducted social marketing research for development of promotional materials and is considering conducting a broader media campaign, along with other states such as Alabama (whose waiver was pending at the time of this survey).

States reported widely ranging enrollment figures (Table IV-3), which is likely to reflect both the different sizes of their eligible populations as well as the success of their outreach strategies. Current enrollment figures for states with waivers approved in 1995 or before reported enrollment figures ranging from 600 in Rhode Island (which recently experienced an approximate 50 percent drop in eligibles due to a broader Medicaid expansion that extended the full scope of benefits to more people) to 41,000 in Maryland. For states that received waiver approval since 1997, a group generally including larger and more populous states than those in the first category, enrollment figures ranged from approximately 8,000 in New York to over one million in California that replaced an existing state-funded program with a Medicaid-financed program.

B. Benefits

Like reproductive health care services covered under state's general Medicaid programs, those covered under state family planning expansion waivers may include a range of benefits, such as gynecological examinations, contraception, sterilization, and screening and treatment services. Some states have used the waiver to provide a set of services directly related to contraception, while other states have included a more comprehensive set of services within their scope of waiver benefits (Table IV-4):

- **Exams and counseling services.** Gynecological exams are a covered service in all states. Typically, these exams are covered when conducted as part of a family planning visit. Broader coverage of this service, however, is provided in Rhode Island, which covers one comprehensive annual gynecological exam and up to three additional visits related to family planning. Contraceptive counseling and/or reproductive health education services are explicitly identified as a covered service in family planning waiver programs far less frequently. Of the five states that include this service (Arizona, California, Missouri, Oregon, and South Carolina), Arizona and California are unique in their identification of education on natural family planning as a component of their programs. A notable feature of South Carolina's waiver program is that education about family planning options and services may be billed in addition to an office visit, initial family planning exam, or postpartum exam;

- **Prescription contraception.** The family planning waiver programs across the states generally cover a comprehensive range of prescription contraceptives including oral contraceptives, intrauterine devices, contraceptive implants and injections, diaphragms and, in Florida and California, cervical caps. Emergency contraception, however, was noted as a covered service only in California;

- **Over-the-counter contraception.** In contrast to the typical coverage of contraceptive prescriptions by family planning waiver programs, over-the-counter contraceptive methods were identified as a covered service in Arizona, California, Delaware, New York, Oregon, Rhode Island, and South Carolina, over half of the states

Table IV-3
Enrollment in Family Planning Waiver Programs

State	Enrollment
Waivers approved in 1995 or before	
Arizona	22,000 (as of August 1999)
Delaware	1,865 (as of August 1999)
Maryland	41,000 (as of September 1999)
Rhode Island	600 (as of September 1999)
Waivers approved in 1997 or after	
Arkansas	48,116 (as of July 1999)
California	1,103,715 (as of June 2000)
Florida	13,637 (represents recipients of services between October 1998 and May 1999)
Missouri	13,269 (as of March 2000)
New Mexico	11,073 (as of June 1999)
New York	8,000 (calendar year 1998)
Oregon	27,000 (as of July 1999)
South Carolina	68,904 (FY 1999, ending June 1999)

Notes: As of January 2000

with waivers. California, reflecting the broad scope of services in its family planning waiver program, includes a broad range of over-the-counter supplies, including male and female condoms and spermicide foam, jelly, inserts, films, and suppositories;

- **Sterilization.** Similar to the broad coverage of sterilization services under states' general Medicaid programs, states also typically include sterilization services in their

Table IV-4

Benefit Coverage in Selected State Family Planning Expansion Waivers

State	Exams & Counseling	Prescription Contraception	Over-the-Counter Supplies	Sterilization	Screening & Treatment	Infertility & Conception
Arizona	✓	✓	✓	✓	✓	
Arkansas	N/A	N/A	N/A	N/A	N/A	N/A
California	✓	✓	✓	✓	✓	✓
Delaware	✓	✓	✓	✓	✓	
Florida	✓	✓		✓	✓	
Maryland	✓	✓		✓	✓	
Missouri	✓	✓		✓	✓	
New Mexico	✓	✓		✓	✓	
New York	✓	✓	✓		✓	
Oregon	✓	✓	✓	✓		
Rhode Island	✓	✓	✓	✓	✓	
South Carolina	✓	✓	✓	✓	✓	

Notes: N/A=Information not available
As of January 2000

waiver programs. In two cases (California and Oregon), sterilization services are covered for men as well as women. The only state that does not cover sterilization services is New York, as the waiver services are currently limited to those that can be provided in family planning clinics; however, plans are underway to expand the scope of services to include surgical procedures as well;

- **Screening and treatment.** In recognition of the impact that cervical cancer, sexually transmitted diseases, and HIV have on reproductive health, most states cover screening services for one or more of these conditions in their waiver programs. Seven states (California, Florida, Maryland, Missouri, New York, Rhode Island, and South Carolina) cover Pap smears, with colposcopy services covered as needed in California, Florida, and Rhode Island. Nine states (Arizona, California, Delaware, Florida, Maryland, Missouri, New Mexico, New York, and Rhode Island) screen for STDs, and all but one (Arizona) also cover STD treatment services. (Rhode Island's coverage of STD treatment is limited to treatment for genital warts.) HIV testing, along with counseling, is covered by six states (Arizona, California, Delaware, Florida, Maryland, and New York);

- **Conception and infertility.** In contrast to the other service categories, which are designed to prevent conception, services to facilitate conception are typically excluded from family planning waiver programs. Given the focus of these waivers on reducing costs associated with unintended pregnancies and births, this is not surprising. The one exception is California, which covers preconception counseling and "limited diagnostic services for fertility management"; and

- **Other services.** In addition to the services discussed above, several states identified covering a few other services under their waiver programs. For example, Florida covers

transportation to receive family planning services, Rhode Island covers rubella immunizations for postpartum women, and Oregon offers home visits or a bilingual provider/interpreter when needed to deliver services.

C. Service Delivery Systems

In designing their family planning expansion programs, states must determine which providers will be eligible to provide family planning services and, in so doing, how open or closed the provider network will be to clients seeking these types of services.

This survey revealed that, in almost all cases, states with expansion waivers designed their systems to facilitate clients' receipt of needed services by encompassing a broad pool of Medicaid providers. In fact, in eight of the 12 states with family planning expansion waivers (Arkansas, California, Delaware, Florida, Maryland, Missouri, New Mexico, and South Carolina) clients may be served by any Medicaid provider who offers these services.

In two states, New York and Oregon, the provider networks for family planning waiver services are generally limited to family planning clinics. In New York, this limitation is a temporary artifact of the state's Medicaid billing system; due to changes in the computer system required for welfare reform, a separate "off-line" billing system was developed for the waiver program, which could only be used by Title X-funded clinics. Therefore, until a new computer system is in place, eligible clients must use these clinics (and the program can only cover services that these clinics can provide). In the future, the state plans to expand the program to any Medicaid provider and to cover all services defined as family planning. In Oregon, the state chose its existing network of Title X clinics as providers for its Family Planning Expansion Project for several reasons, including the clinics' expertise in delivering family planning services to low-income, high-risk populations; the focus on education and counseling; the ability to provide family planning services and supplies in one visit; the adherence to the rigorous administrative and clinical standards required of Title X providers; and widespread accessibility of clinics throughout the state. Other providers may participate in the Expansion Project if they meet Title X standards and demonstrate their ability to meet an unmet community need; all Indian Health Service and tribal clinics in the state are eligible for participation in the provider network.

In the remaining two states, Arizona and Rhode Island, participants in the waiver programs are served through the states' Medicaid managed care systems. For example, in Rhode Island, women who were enrolled in a RIte Care health plan during pregnancy are required to remain with the same health plan after the 60-day postpartum period, at which time the Medicaid agency notifies the plan of the member's change in eligibility to the state's Extended Family Planning program.

D. Payment

Along with the decision about who is eligible to provide services to family planning waiver program participants, states must also determine how these providers will be reimbursed. Corresponding to the decisions by the states with expansion waivers regarding their provider

networks, this survey found that the ten states that allow family planning services to be rendered by any Medicaid provider reimburse these providers on a fee-for-service basis. In all of these cases, the rates paid for services delivered to waiver clients are the same as those paid for family planning services delivered to non-waiver clients receiving care on a fee-for-service basis; that is, the standard Medicaid fee schedule is applied.

The two states with waiver programs that deliver family planning services through a managed care system reimburse for these services on a capitated basis. Rhode Island reimburses health plans a capitated rate for waiver program enrollees of $26 per member per month. Arizona negotiates the capitation rate with the participating health plans.

E. Evaluation Results

With the number of states implementing family planning expansion waiver programs growing each year, interest is also growing in understanding how effective these efforts are in reducing pregnancies and births, increasing interpregnancy intervals, and, of course, saving money. Toward this end, eight of the 12 states with family planning waivers (Arizona, California, Florida, Maryland, New Mexico, Oregon, Rhode Island, and South Carolina) indicated that they are conducting evaluations of their waiver programs. Of the four that indicated that they are not currently conducting evaluations, one (Arkansas) indicated plans to do so in the future.

While data are not yet available from all of these evaluation efforts, promising results have been found in at least two states that implemented programs a number of years ago targeting postpartum women:

- Maryland's report of evaluation results from the first two years of the five-year waiver program found that despite lower-than-anticipated enrollment in the program and utilization of services, the rate of pregnancies and births among the Medicaid population decreased during both of the program's first two years. The report tentatively concludes (given the early phase of the program being evaluated) that the program is cost effective. It can save Medicaid expenditures by preventing subsequent pregnancies and births in women who would otherwise lose Medicaid coverage after the 60-day postpartum period. The program was found at that time to be budget neutral and to have averted approximately half a million dollars in Medicaid expenditures.
- An evaluation of Rhode Island's RIte Care Medicaid managed care program—of which the state's family planning expansion program was an important component—has found that program's Medicaid expansions and implementation of managed care has had a dramatic impact on several key indicators. As discussed in Gold (1999), the program has been credited with cutting the number of women having Medicaid-funded deliveries within nine months of a previous birth by nearly half, within the program's first three years.

  In addition, the difference between privately-insured and Medicaid-insured women having short interpregnancy intervals (defined as less than 18 months) was virtually eliminated. In light of the cost of publicly-funded deliveries and infant care, the state estimates that it has saved more than two and one-half times its investment in Medicaid-covered family planning services.

As more states adopt a broader approach in their waiver expansion efforts—that is, targeting their programs to women under a certain income threshold in addition to postpartum women losing Medicaid coverage—there is also a keen interest in evaluation of these programs. Florida is one state taking this broad-based eligibility approach that is undertaking an extensive evaluation. The state has contracted with the University of South Florida to conduct a multi-pronged five-year evaluation of their waiver program including a telephone survey of people eligible for, as well as those who have received, services under the waiver program to determine their knowledge of the program and barriers to care; a phone-based client satisfaction survey; and interviews with key stakeholders. In addition, a demographic profile of users will be developed annually, and Medicaid claims data will be used to analyze the program's impact on access, utilization, and cost of services.

Chapter V: Systems Issues

V. Systems Issues

Medicaid is the leading source of funding for family planning services in the United States. However, a range of other funding sources also support a system of family planning providers who serve both Medicaid-eligible and uninsured clients. This chapter describes this "safety net" system, its relationship to the services financed by Medicaid, and how policy changes are affecting this system's ability to serve its target population. The information in this section comes from two main sources: public health officials, who provided data about the family planning programs that they administer, and reproductive health association representatives, who provided more qualitative information about family planning services provided in their clinics. It should be noted that the response rate from these informants was somewhat lower than from Medicaid officials: interviews were conducted with 47 public health officials and 34 representatives of clinic associations.

In addition to Medicaid, family planning services are supported by five distinct funding sources (mentioned earlier in Chapter 2), which are generally administered through state public health departments and private nonprofit agencies. These programs include Title X, Title V, Title XX, TANF, and state funds and vary in funding:

- **Title X.** The National Family Planning Program provides funds to every state, with funding amounts ranging from $459,452 in North Dakota to $16 million in California. Forty-one states reported spending at least $500,000 and 34 states exceeded $1 million in Title X funds.
- **Title V.** Thirty-one states[3] devote Title V funding (The Maternal and Child Health Block Grant, Title V of the Social Security Act) to direct family planning services, ranging from $10,000 in Nebraska to $3 million in North Carolina. Twenty-two states reported spending at least $200,000 and 12 states exceeded $1 million.
- **Title XX.** Eleven state public health agencies receive Title XX funding (The Social Services Block Grant, Title XX of the Social Security Act) for family planning services, with a range of $5,000 in Utah to $26 million in Texas. Ten states (Illinois, Indiana, Iowa, Minnesota, Mississippi, New Hampshire, New Jersey, Pennsylvania, Texas, and Vermont) reported spending at least $100,000 and five of these states (Illinois, Indiana, New Jersey, Pennsylvania, and Texas) reported spending at least $1 million in Title XX funds.
- **TANF.** The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 replaced Aid to Families with Dependent Children (AFDC) with Temporary Assistance to Needy Families (TANF). States are allowed to use their TANF funds at their own discretion, including providing family planning services. Eleven states earmark TANF funds for family planning, ranging from $110,000 in West Virginia to $10 million in

[3] Alabama, Alaska, Arizona, Arkansas, Delaware, Hawaii, Idaho, Illinois, Indiana, Kentucky, Michigan, Minnesota, Missouri, Mississippi, Nebraska, New Jersey, New Mexico, New York, Nevada, North Carolina, North Dakota, Ohio, Oregon, Rhode Island, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, and Wyoming.

New York (Table V-1). Ten states reported spending at least $500,000 and six states exceeded $1 million. States may also transfer up to ten percent of their TANF funds to the Social Services Block Grant (SSBG) program to compensate for cuts in SSBG funding. Eight states reported transferring TANF funds to their Title XX programs.

- **State Funds.** Finally, many states use their general funds to support family planning services. Thirty-four state family planning programs[4] reported receiving state funds, ranging from $50,000 in Nevada to $180 million in California. Thirty-one states reported spending at least $100,000 and 21 states surpassed $1 million.

These funds support a range of types of community-based providers, including local health departments (in 39 states), free-standing clinics (in 37 states), health centers (in 25 states), hospitals (in 26 states), and schools (in Florida, Hawaii, Utah, and Virginia). In addition, a few states use public funds to support family planning services in private doctors' offices, university health centers, community action agencies, and nursing clinics.

State public health programs can also support family planning through in-kind contributions rather than direct funding. For example, in West Virginia, a special agreement is constructed with an organization such as a university health center or Job Corps in which the state's family planning program provides information, supplies, and support in exchange for statistical information about the clients served.

A. Eligibility

In general, these funding sources primarily support the provision of family planning services to people who are not eligible for Medicaid. Among women of childbearing age, this population is significant, as Medicaid eligibility for non-pregnant women (and men) is based on the narrow eligibility criteria for the former AFDC program.

In contrast, eligibility for safety net family planning services is broad. The Federal Title X program requires that services be available to all, regardless of age, marital status, or income (although sliding-scale fees may be charged to those with incomes between 100 and 250 percent of FPL, while those above 250 percent of FPL are charged a full fee). About half of the responding states reported that they do not restrict eligibility for services funded through Title V, Title XX, and state funds. The other half of the states blend funding from a variety of sources into a single program, applying the Title X Federal guidelines to these other funding sources. Of these states, 14 states reported restricting services to women of reproductive age or reproductive capacity.

If a minor requests confidential services, the minor is charged based on the minor's income and not the family's income (Kring, 1997). While most states reported using the Federal Title X income standards for services funded by other sources as well, a few used a lower income limit.

[4] Alabama, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Kansas, Kentucky, Massachusetts, Maryland, Maine, Michigan, Minnesota, Missouri, Mississippi, Nebraska, New Hampshire, New Jersey, New Mexico, New York, Nevada, North Carolina, Ohio, Oregon, Rhode Island, Tennessee, Virginia, Vermont, Washington, and West Virginia

Table V-1
States Using TANF Funds for Family Planning, FY 2000

State	Earmark TANF funds for family planning	Transfer TANF funds to Social Services Block Grant
Alabama	$ 850,000	
Arizona	$ 2,000,000	
Florida	$ 1,500,000	✓
Illinois	$ 1,000,000	
Indiana	$ 1,000,000	
Iowa	$ 1,155,000	✓
Kentucky	$ 500,000	✓
Maine	-	✓
New York	$ 10,000,000	✓
North Carolina	$ 3,600,000	
Ohio	$ 250,000	✓
Texas	-	✓
Vermont	-	✓
West Virginia	$ 110,000.00	

Notes: As of January 2000

In Alaska, for example, Title V-funded services are limited to those with family incomes below 200 percent of FPL. For family planning services specifically funded by Title V, Arizona limits services to those persons whose family incomes are below 150 percent of FPL, and Texas provides Title V-funded services to women up to 185 percent of FPL. Similarly, most state-funded family planning services use the Title X income standards, but Oregon limits state-funded services to those with family incomes below 185 percent of FPL, while California, Massachusetts, Minnesota, and Washington limit family planning services to those under 200 percent of FPL.

As mentioned above, the only eligibility criterion for subsidized Title X services is income. However, Federal Title X regulations prohibit "means testing;" that is, grantees may not require income documentation as a condition for receiving services. Nonetheless, 24 states reported that they request documentation of income, such as pay stubs, income tax returns, TANF cards, or Medicaid cards, while 31 states allow clients to verify their income themselves. Some of these states, however, reported that their delegate agencies may request income documentation. (Table V-2).

Many state family planning agencies were able to provide data on the demographic distributions of their client populations:

- **Gender.** In general, family planning programs primarily serve women. Of the 23 states from which data were available, women represented between 81 percent and nearly 100 percent of clients.
- **Age.** In the 35 states that reported the age distribution of their clients, the largest percentage of users were in their twenties. This group represented between 31 percent and 56 percent of total users. Adolescents comprised the second largest group, representing between 19 percent and 47 percent of users.
- **Race/Ethnicity.** Thirty-four states were able to report on the racial and/or ethnic distribution of their family planning clients. In most states, whites represented the plurality of clients, ranging from 21 to 99 percent of users, with the highest proportions in the Northeast and the lowest in the South and West. African Americans represented from 0.5 to 65 percent of clients, with the highest percentages in the South. Latinas comprised from 0.2 percent to 61 percent of users, with California reporting the highest percentage. Native Americans represented from .02 percent to 3.5 percent of clients, with Alaska reporting the largest native population.
- **Insurance Status.** The proportion of total clinic clients who are on Medicaid is relatively low. Public health officials in 15 states were able to report on the insurance status of their programs' clients; of these, a relatively small proportion were Medicaid-eligible, ranging from two percent to 34 percent.

In addition, 22 states reported that their family planning programs serve a significant number of clients who do not qualify for Medicaid due to their immigration and residency status (Table V-3). This is reported to be a particularly serious issue in the Southwestern and Western states.

Recent policy changes, including welfare reform, implementation of Medicaid managed care and family planning waivers, and implementation of S-CHIP have affected the demographics of family planning clients. Public health officials and clinic representatives in 25 states report an increase in their total client populations or in specific groups of clients. Of these states, Alaska, Connecticut, Florida, Kansas, North Dakota, and Nevada report an increase in the number of adolescents served, while Indiana and Kentucky have seen an increase in the number of teens who are eligible for Medicaid since the implementation of S-CHIP. Five states (Indiana, Kansas, Nevada, Virginia, and Ohio) report an increase in low-income clients, and three (Alaska, North Dakota, and Nebraska) have seen an increase in the number of uninsured clients who are potentially eligible for Medicaid. Nevada officials attribute this to the effects of welfare reform, while those in Alaska and Nebraska attribute it to the difficulty of enrolling in Medicaid. Several states report an increase in minority clients and an aging client population, although this may be related to demographic shifts rather than to policy changes. Seven states (Alabama, Idaho, Kansas, Mississippi, Oklahoma, Oregon, and Tennessee) have seen an increase in the proportion of Hispanic clients, and Kansas reports an increase in African American clients. Four states (California, Iowa, New Mexico, and Utah) report an increase in undocumented or immigrant clients. Finally, intensive outreach to men has resulted in an increase in the number of male clients in California, Washington, and Wyoming.

On the other side of the spectrum, public health officials and reproductive health clinic representatives in 26 states reported a decrease in the number of individuals eligible for Medicaid

Table V-2.
Eligibility Standards for Family Planning Services Under Title X and non-Title X Funds

	Title X Eligibility Standards: Income Verification		Non-Title X Eligibility Standards	
State	**Self Report**	**Documentation Required**	**Age Limit**	**Income Limits**
United States Total	**31**	**24**	**16**	
Alabama	✓		Reproductive age	Same as Title X
Alaska	✓		Reproductive age	Up to 200% FPL for services funded by Title V.
Arizona	✓	In 2000, community health centers will begin requesting pay stubs.	Reproductive age	Up to 150% FPL for services funded by Title V.
Arkansas	✓		No age limit	Same as Title X
California	✓		Women of reproductive capacity	Up to 200% FPL for state funded services.
Colorado	✓		Reproductive age	Available to all
Connecticut	✓		No age limit	Up to 185% FPL for state funded services.
Delaware	✓		Reproductive age	Available to all
District of Columbia	- - -	- - -	- - -	- - -
Florida		Pay stubs, or TANF card, or note from family member.	No age limit	Available to all
Georgia	✓	Some local health departments require income verification by asking for pay stubs.	Reproductive age	Same as Title X
Hawaii	✓		Reproductive age	Same as Title X
Idaho	✓		No age limit	Same as Title X
Illinois	✓	Family planning agencies may ask for income verification but they may not require it.	No age limit	Same as Title X
Indiana	✓		Reproductive age	Same as Title X
Iowa	✓		No age limit	Up to 100% FPL for services funded by Title V.
Kansas	✓	Some clinics require pay stubs.	No age limit	N/A
Kentucky		A variety of income verification is required including pay stubs and income tax forms.	No age limit	Same as Title X
Louisiana	- - -	- - -	- - -	- - -
Maine	✓		No age limit	Same as Title X
Maryland		Pay stubs requested.	No age limit	Same as Title X
Massachusetts	✓		No age limit	Sliding scale 100%-200% FPL for state funded services.
Michigan	✓		No age limit	Same as Title X
Minnesota		Income verification varies, decision made by local agencies.	No age limit	Up to 200% FPL for state funded services.
Missouri	✓		Reproductive age	Available to all
Mississippi	✓	No income verification for clients 19 years of age and younger. Otherwise, clients must sign a standard self-declaration income form. Some local health departments require pay stubs.	No age limit	Same as Title X
Montana	- - -	- - -	- - -	- - -
Nebraska	✓	The majority of clinics require proof of income such as income tax form or pay stub, but some clinics allow clients to self-report.	No age limit	Same as Title X
Nevada		Pay stubs or income tax return.	Reproductive age	Same as Title X
New Hampshire		Pay stubs, letter from employer, signed statement, or Medicaid card.	No age limit	Same as Title X
New Jersey		Pay stubs or a copy of income tax return.	No age limit	Same as Title X
New Mexico		Pay stubs.	No age limit	Same as Title X
New York	✓		No age limit	Same as Title X
North Carolina	✓	A few local agencies require pay stubs.	No age limit	Same as Title X
North Dakota		Most agencies require clients to complete an income verification worksheet. However, some agencies may also require up to 3 income verification documents.	No age limit	N/A (Title V used for administrative purposes.)
Ohio		Pay stubs.	No age limit	Available to all
Oklahoma	✓		Women of reproductive capacity	N/A
Oregon	✓		Reproductive age	Same as Title X
Pennsylvania	✓		No age limit	Same as Title X
Rhode Island		Income documentation not required but may be requested.	Reproductive age	Eligibility for Title V and state-funded services based on insurance status, not income
South Carolina	- - -	- - -	- - -	- - -
South Dakota		Pay stubs and income tax return. Income verification form is the same form used by WIC and Children's Health Services.	Women of reproductive capacity	Available to all
Tennessee		One month of pay stubs or income tax return.	No age limit	Same as Title X
Texas	✓		Reproductive age	Up to 150% for Title XX and up to 185% for Title V funds.
Utah	✓	No documentation required by Title X grantees, but local health departments may require pay stubs.	No age limit	Available to all
Vermont		Pay stubs.	No age limit	Available to all
Virginia		Pay stubs or income tax return.	No age limit	Available to all
Washington	✓		No age limit	Same as Title X
West Virginia	✓		No age limit	Same as Title X
Wisconsin		Pay stubs.	No age limit	Same as Title X
Wyoming	✓		No age limit	Available to all

Notes: - - - = States in which the public health agencies did not respond
As of January 2000

in their total client population. They attributed this decline to the effects of Medicaid managed care (in 18 states), welfare reform (in Alaska, Arizona, Florida, and Ohio), and an improved economy (in Iowa).

Table V-3.

States Providing Subsidized Family Planning Services to a Substantial Population of Clients Ineligible for Medicaid Due to Immigration or Residency Status

Northeast	Southeast	Midwest	Northwest	Southwest
Massachusetts	Alabama	Illinois	Alaska	Arizona
Maryland	Arkansas	Indiana	Oregon	California
New Jersey	Kentucky	Iowa	Wyoming	New Mexico
New York		Kansas		Texas
Rhode Island		Michigan		Oklahoma
		Wisconsin		

Notes: As of January 2000

B. Benefits

In addition to serving clients who are uninsured and ineligible for Medicaid, family planning clinics generally serve Medicaid-eligible clients and receive Medicaid reimbursement for services provided to them. In addition, they may provide services that Medicaid does not cover. In some states, these services are explicitly covered by state- or Title X-funded programs; in others, reproductive health clinic representatives reported that their clinics provide the services whether or not there is a specific source of reimbursement.

Public health officials in ten states (Arkansas, California, Hawaii, Maine, Nebraska, New Mexico, North Carolina, Tennessee, Utah, and West Virginia) reported that their programs fund services not covered by Medicaid in their states. These services include community-based education, outreach, and care coordination services (in California, Hawaii, Nebraska, and North Carolina) as well as direct client services. The client services most commonly noted in this category include STD treatment (in Arkansas, Nebraska, New Mexico, and Utah); non-prescription supplies (in Maine, Tennessee, and West Virginia); and counseling services (in Arkansas and Nebraska).

Family planning clinic associations also reported on the services they provide for which they do not receive Medicaid reimbursement (Table V-4):

- In seven states (Georgia, Illinois, Indiana, Iowa, Minnesota, Missouri, and Nebraska), clinics report providing contraceptive counseling and health education services that are not covered by Medicaid.
- Clinic associations in seven states (Florida, Missouri, New Hampshire, New Mexico, North Dakota, Oklahoma, and Tennessee) reported providing contraceptive supplies

without Medicaid reimbursement. These most often included condoms and spermicide. In addition, clinics in four states (Florida, Iowa, Kansas, and Missouri) reported providing emergency contraception without Medicaid coverage.

- Clinics in nine states reported providing testing and treatment services for cervical cancer, STDs and HIV that were not covered by Medicaid. These included pap smear and/or STD lab services (in Alaska, Missouri, Illinois, Nebraska, and Wyoming), colposcopy (in Alaska, Oregon, and Utah), STD treatment services (in Missouri and Oregon) and HIV testing (in Kansas, Oklahoma, and Oregon).

Table V-4

Services Provided by Family Planning Clinics without Medicaid Reimbursement*

State	Counseling and Education	Contraceptive Supplies	Testing and Treatment Services	Emergency Contraception	Sterilization, Infertility and Conception Services**
Alabama					✓
Alaska			✓		
Arkansas					✓
Florida		✓		✓	
Georgia	✓				✓
Illinois	✓		✓		✓
Indiana	✓				✓
Iowa	✓			✓	✓
Kansas			✓	✓	✓
Minnesota	✓				
Missouri	✓	✓	✓	✓	✓
Nebraska	✓		✓		✓
New Hampshire		✓			✓
New Mexico		✓			✓
North Dakota		✓			
Oklahoma		✓	✓		
Oregon			✓		
Tennessee		✓			✓
Utah			✓		
Wyoming			✓		

Notes: *As reported by representatives of family planning clinic associations
** Includes preconception counseling
As of January 2000

- Clinic associations in 12 states reported providing sterilization, infertility, and conception services that are not reimbursed by Medicaid. The service most commonly reported in this category is preconceptions counseling, which clinics in ten states (Arkansas, Georgia, Illinois, Indiana, Kansas, Missouri, Nebraska, New Hampshire, New Mexico, and Tennessee) report providing without Medicaid payment. Other such

services include infertility testing (provided by clinics in Iowa, Missouri, and New Mexico), infertility treatment (in Missouri and New Mexico) and tubal ligation and vasectomy (in Alabama and Arkansas).

Although family planning programs may cover a wide range of services, the cost of these services may limit clients' access to them. Newer contraceptive methods, particularly Depo-Provera, are considerably more expensive than oral contraceptives and barrier methods, an expense that can place a severe burden on limited program budgets. In fact, 20 states reported that the use of family planning funds had changed due to the increasing cost of supplies such as Depo-Provera and services such as colposcopy. To address these constraints, states may limit the availability of specific services; for example, family planning clinics in South Dakota put limits on Depo-Provera, and in Tennessee all new clients are given oral contraceptives. Nebraska, Mississippi, and Tennessee found other funds such as state, tobacco settlement and county funds to offset the high costs of contraceptive services and supplies. In Alaska and North Dakota, funds have been shifted from education and outreach to clinical services.

C. Payment/Financial Issues

Although Medicaid is the leading funder of family planning services in the United States, Medicaid reimbursement is only a small portion of reproductive health clinics' budgets. Clinic representatives in 31 states report that Medicaid reimbursement represents between two and 28 percent of their clinics' total family planning budgets. Of these states, 23 states reported that Medicaid reimbursement was less than 20 percent of their total budgets. On average, the largest proportion of clinics' revenues come from out-of-pocket payments from uninsured clients, which represent from six to 95 percent of the budgets of clinics and associations interviewed. For clinics that receive Title X funds, these represent between eight and 49 percent of revenues, and other public monies represent from one percent to 57 percent of funding.

The proportion of clinics' total family planning budgets that can be attributed to Medicaid reimbursement reflects both the percentage of clients who are Medicaid-eligible as well as Medicaid's reimbursement rates. Medicaid reimbursement is often reported to be low: clinic representatives in 19 states reported rates to be inadequate, while clinic representatives in only 12 states believe that Medicaid reimbursement rates are adequate. The major causes of complaint about Medicaid fees were that they do not cover clinics' costs and that they had not been increased to keep pace with inflation and the increasing cost of supplies.

Although Medicaid rates have remained stable in most states, many report an increase in public health funds in the past five years. Twenty-four states have seen an increase in funds, while only six (Alabama, New Mexico, Ohio, Rhode Island, Virginia, and Washington) have seen a decrease. Changes in funding have had a direct effect on the supply and capacity of family planning providers. Officials in 18 states report that funding increases have allowed them to increase the size or capacity of their provider networks, while those in seven states where funding has remained stable or decreased (Alaska, Alabama, Indiana, Mississippi, New Mexico, Virginia, and Washington) report a decline in the number of providers funded, and some have been prompted to charge higher fees or institute waiting lists for services.

In theory, Medicaid is the payor of last resort for its enrollees. However, Title X and other family planning programs rarely reimburse clinics on a fee-for-service basis; rather, they provide grants to "delegate agencies" that are often based on years-old funding formulas that were originally based on costs, needs, caseload, or utilization levels and have rarely been updated. Since Medicaid reimbursement is only a small portion of the clinics' overall budgets, some clinics report that the various public health funding sources provide general operating revenue that serves to fill in financial gaps left by low Medicaid rates.

D. System Capacity

To summarize, dedicated family planning funding appears to serve three main purposes: first, to support the provision of reproductive health services for the substantial proportion of low-income women and men who are not eligible for Medicaid; to support payment for services not covered by Medicaid; and to subsidize the provision of Medicaid-covered services for which payment levels do not cover providers' costs.

These last two roles are based on the assumption that family planning providers are frequently the providers of services to Medicaid-eligible clients. As discussed in the previous chapter, representatives of family planning clinics in many states report that Medicaid-eligible clients, including those enrolled in managed care plans, often prefer to use community-based family planning clinics rather than their primary care providers for reproductive health services. The major reasons for this preference include the assurance of confidentiality (especially for adolescents), shorter waiting times for appointments, convenience of clinic hours, and providers' attitude toward and respect for their clients. For example, reproductive health clinic representatives in Maine cite primary care providers' lack of training in talking about sexual issues as a barrier.

Nonetheless, this system can impose barriers to care as well. Public health officials in 13 states cited clinic hours as the most important barrier for those whose income is above the Federal poverty guidelines. Officials in ten states cited out-of-pocket expenses as another significant barrier. Public health officials in Idaho and Illinois also cited limited funding for public health services as restricting access for low-income women and men.

Other barriers are attributable to lack of outreach or education: limited awareness of services and a stigma associated with family planning were cited as barriers to services in 16 states. For immigrants, these barriers can be compounded by the assumption that they do not qualify for public benefits or the fear that use of services will threaten their eligibility for citizenship. While public health agencies and clinics are heavily involved in outreach to promote family planning, funding constraints can limit their capacity and, thus, their ability to recruit new clients. Clinic representatives in several states reported that they hesitated to conduct aggressive outreach campaigns because their providers are at full capacity already and cannot handle a greatly increased caseload.

Barriers to care within the publicly-funded family planning system have a significant impact, because these clinics represent the "safety net" that provides family planning services to those not eligible for Medicaid as well as provides services not covered by Medicaid. The barriers become increasingly relevant as the population using the system increases, particularly among

high-risk groups such as adolescents, low-income clients, and the uninsured. Moreover, many Medicaid clients prefer community-based clinics. However, Medicaid represents only a small portion of clinics' budgets; larger contributors are the various sources of funding administered by state public health agencies. If more funds were available through these sources, public health officials and clinic representatives suggest that their programs could improve access in several ways. Officials would like to serve more clients; provide more supplies and services; increase clinic hours; establish satellite clinics; and improve education and outreach to both clients and providers. Public health officials and clinic representatives also suggested improving collaboration and coordination between public health programs and state Medicaid programs in order to increase the capacity of the system as a whole to provide family planning services to all who need them.

Chapter VI: Respondents' Perspectives

VI. Respondents' Perspectives

The state officials interviewed were asked to provide their perspectives on access to family planning services in their states. To assess their view of the overall effect of policy and systems changes on access and the prospects for its improvement, Medicaid officials, public health representatives, and representatives of family planning clinics were asked to comment on access issues in their states, the barriers to access, and the policy changes they would recommend to address those barriers.

When asked about the effect of their states' policy changes on access to care, Medicaid officials were overwhelmingly positive; 19 Medicaid officials reported that the introduction of managed care had improved access to services, generally by increasing the number and range of types of providers available, particularly private providers. In addition, six of the states with family planning waivers singled out those programs as having contributed greatly to improving access. Other policy changes were noted as well: in Montana, officials highlighted the positive effect of increasing reimbursement rates, and in Oklahoma, the increase in income eligibility for Medicaid to 185 percent of poverty was noted as improving access to care.

Although several state officials felt unable to comment on the level of access to care in their states, few reported negative effects of their policies. One exception was North Carolina, where access to family planning appears to have diminished in the one county in which capitated managed care has been implemented. Similarly, New Jersey officials were initially concerned that their capitated program would restrict access, but they reported that continued education of plans about the open access requirement appears to have been successful.

Not surprisingly, public health officials were somewhat less sanguine than the Medicaid officials about the effects of managed care on access to family planning services under Medicaid. However, officials in 12 states did acknowledge that access under Medicaid was better than that under other family planning programs, primarily because of the wider choice of providers, particularly private providers, available to Medicaid eligibles. In addition, officials in Alabama, Oregon, and Utah noted that Medicaid clients' access to specific services (primarily contraceptive injections, IUDs, and sterilization) was better than that in the public health system, as the cost of these services limits clinics' ability to provide them to all who need them.

Twenty public health representatives reported that Medicaid and public health programs provided equal access, while ten felt that access under Medicaid was worse. The major reasons for limited access under Medicaid were long waits for services, restricted provider networks, and burdensome eligibility and enrollment processes. Several state officials also noted concerns about the quality of care provided under Medicaid; California officials, for example, felt that managed care plans did not offer the full array of family planning options and were not as "youth-friendly" as family planning clinics. In Nebraska and West Virginia, officials reported that the private providers available under Medicaid did not provide the same level of education and counseling about family planning methods that clinics did.

Despite their generally positive view of their programs, Medicaid officials did acknowledge a wide range of barriers to care. The issues most commonly mentioned were transportation, particularly in rural areas (a concern in ten states) and shortages of providers or geographic availability of services (mentioned in eight states). However, many Medicaid informants noted access issues more directly related to the structure and functions of the Medicaid program, including:

- Providers not accepting Medicaid or limiting their Medicaid caseloads (mentioned in six states);
- Medicaid eligibility standards, particularly the loss of coverage after 60 days postpartum and low income eligibility thresholds (mentioned in five states);
- The need to better educate Medicaid recipients about how to use family planning services (mentioned in three states); and
- The problem of eligible people not enrolling in Medicaid (mentioned in one state).

Other barriers included cultural and language issues, child care, and confidentiality, especially for adolescents.

Medicaid, public health, and clinic representatives suggested a range of policy changes to address these barriers and improve access to family planning services. Medicaid officials concentrated on policy recommendations directly related to the Medicaid program, while public health and clinic representatives provided a broader range of recommendations. Suggestions that were mentioned by all types of informants included the following:

- **Funding.** Five Medicaid officials and seven public health representatives recommended increased Medicaid fees or increased funding for family planning more generally as a mechanism for increasing access. Some respondents were more specific: Oklahoma Medicaid officials recommended increased capitation rates in rural areas; Minnesota public health officials suggested that funding be better targeted to adolescent services; and Nevada public health representatives recommended increased funding for outreach.
- **Outreach and education.** Six state Medicaid agencies recommended increased outreach and education about services to potential clients which would encourage better utilization of and compliance with family planning; in Oregon and Rhode Island, this suggestion focused specifically on teens. Similarly, public health officials in two states recommended specific forms of outreach: Kentucky officials suggested that information about family planning be enclosed with welfare checks, and Oklahoma officials suggested better education of clients about new family planning methods. Improved outreach to and education of Medicaid clients, particularly regarding open access provisions, was the most common suggestion among family planning clinic representatives.
- **Expanded use of waivers.** Medicaid officials in three states (Nevada, Kansas, and South Carolina) suggested the use of expanded family planning programs such as those implemented under 1115(a) waivers to improve access, with South Carolina and Nevada officials specifically recommending that these programs become a Medicaid

option that states can add without Federal approval. This suggestion was also made by public health officials in Idaho and Kansas. Several clinic representatives also suggested expansions of Medicaid eligibility or the use of waivers to increase access.

- **Changes to Medicaid.** Medicaid, public health, and clinic officials suggested a range of Medicaid policy and implementation measures to reduce barriers to family planning services. These included the use of a PCCM rather than a capitated model of managed care; the expansion of managed care; a more complete de-linking from the welfare system; expanding eligibility; collecting better encounter data from managed care plans; paying providers in a more timely manner; broadening the definition of family planning; and requiring plans to cover a more comprehensive package of services.
- **Provider network issues.** Several Medicaid officials suggested efforts to expand or improve the range of providers available to clients. These included expanded use of nurse midwives and nurse practitioners; providing technical assistance to providers; and enhancing the emphasis on prevention in medical education. Similarly, public health officials in Indiana and New Mexico recommended that Medicaid programs use a broader provider network.

In addition to these recommendations, public health officials in several states suggested policy changes to improve coordination across programs and systems, ranging from issues of client-level coordination to program- and policy-level collaboration. For example, Alaska officials suggested that family planning services could be better linked with postpartum care to assure a smoother transition from one system to the other. In California, officials recommended that those responsible for different funding sources be encouraged to talk to each other more regularly, while those in Indiana went a step further, recommending that Title V, Title X, and Title XX funding all be administered by a single agency. The specific relationship between public health and Medicaid was mentioned in two states: in New Mexico, public health officials suggested that the Medicaid agency communicate with providers more regularly, specifically about the family planning waiver, and in Virginia, public health officials suggested that their agency work more closely with Medicaid. Finally, Oregon officials addressed coordination at the Federal level, suggesting that HCFA, the Office of Population Affairs, the Maternal and Child Health Bureau, and the Centers for Disease Control and Prevention develop a closer working relationship, and specifically that they develop a common definition of family planning that could be implemented consistently by the states.

Chapter VII: Conclusions

VII. Conclusions

The findings of this survey paint a complex picture of the systems low-income women and men rely on for family planning services. A number of these findings give cause for concern about access to family planning and its consistency across the states:

- In general, Medicaid covers a broad range of services, however, the states vary substantially in the family planning services covered under their Medicaid programs and in the information provided to the program's enrollees about these services;
- As Medicaid systems embrace managed care, state officials typically lack tools to measure the effect of these new arrangements on access to and use of family planning services. Moreover, the specificity of contract language regarding family planning varies widely, and state officials are not necessarily informed about what services managed care plans actually provide;
- Despite the importance of family planning to the success of welfare reform, the connections among TANF programs, Medicaid agencies, and family planning clinics do not appear to be strong. Few states report using TANF funds for family planning services, and few clinics are involved in informing TANF recipients of their continued eligibility for Medicaid; and
- The various sources of funding for family planning services, including Medicaid, Title X, Title V, Title XX, and state funds, are not always well coordinated, and many states do not take full advantage of the availability of the 90 percent match for Medicaid-funded family planning services.

Clearly, the issue of the definition of family planning is a critical one. It is evident from this survey that different programs' and providers' definitions of family planning do not coincide, and that these differences create the potential for confusion and limits on access to care. Perhaps more importantly, this survey revealed that while policies that are intended to increase access to family planning may be in place, including waiver programs and managed care arrangements, it is unclear that their implementation fully supports this goal. Clients may not be informed about their right to use out-of-plan providers of family planning services, which may limit their access to providers who have a long history of serving low-income women. If women are enrolled in faith-based plans or use faith-based providers within their plans, their options may be even more strictly limited. Moreover, state Medicaid agencies have little information about the quality of family planning services provided within managed care plans, and state agencies and community-based providers may not even agree on the definition of quality in family planning services. These issues all bear closer scrutiny on the local level to determine whether the reality of Medicaid's family planning services meets its policy goals.

Appendix A: Summary Tables

Table A-1.

Public Health Coverage of Exams, Counseling, and Prescription Contraception

State	Exams and Counseling Services				Prescription Contraception			
	Title X	Title V	Title XX	State Funds	Title X	Title V	Title XX	State Funds
United States Total	***46***	***31***	***10***	***32***	***47***	***27***	***9***	***33***
Alabama	✓	✓	✓	✓	✓	✓	✓	✓
Alaska	✓	✓			✓	✓		✓
Arizona	✓	✓			✓	✓		
Arkansas	✓	✓		✓	✓			✓
California	✓			✓	✓			✓
Colorado	✓			✓	✓			✓
Connecticut	✓	✓	✓	✓	✓	✓	✓	✓
Delaware	✓	✓		✓	✓	✓		✓
District of Columbia	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -
Florida	✓			✓	✓			✓
Georgia	✓			✓	✓			✓
Hawaii	✓	✓			✓	✓		
Idaho	✓	✓			✓			
Illinois	✓	✓	✓	✓	✓	✓	✓	✓
Indiana	✓	✓			✓	✓		
Iowa	✓		✓		✓			
Kansas	✓				✓			
Kentucky	✓	✓	✓	✓	✓	✓	✓	✓
Louisiana	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -
Maine	✓			✓	✓			✓
Maryland	✓			✓	✓			✓
Massachusetts	✓			✓	✓			✓
Michigan	✓	✓		✓	✓	✓		✓
Minnesota	✓			✓	✓			✓
Mississippi	✓	✓		✓	✓	✓		✓
Missouri	✓	✓		✓	✓	✓		✓
Montana	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -
Nebraska	✓				✓			
Nevada	✓	✓		✓	✓	✓		✓
New Hampshire	✓		✓	✓	✓		✓	✓
New Jersey	✓	✓	✓	✓	✓	✓	✓	✓
New Mexico	✓	✓		✓	✓	✓		✓
New York	✓	✓		✓	✓	✓		✓
North Carolina	✓	✓		✓	✓	✓		✓
North Dakota	✓				✓			
Ohio	✓	✓		✓	✓	✓		✓
Oklahoma	✓			✓	✓			✓
Oregon	✓	✓		✓	✓	✓		✓
Pennsylvania	✓	✓	✓	✓	✓		✓	✓
Rhode Island	✓				✓			
South Carolina	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -
South Dakota					✓	✓		
Tennessee	✓	✓		✓	✓	✓		✓
Texas	✓	✓	✓		✓	✓	✓	
Utah	✓	✓			✓	✓		
Vermont	✓		✓	✓	✓		✓	✓
Virginia	✓	✓		✓	✓	✓		✓
Washington	✓			✓	✓			✓
West Virginia	✓	✓		✓	✓	✓		✓
Wisconsin	✓	✓			✓	✓		
Wyoming	✓	✓			✓	✓		

Notes: - - - = States in which public health agencies did not respond to the survey.
As of January 2000

Table A-2.
Public Health Coverage of Over the Counter Contraception and Sterilization

State	Over the Counter Contraception				Sterilization*			
	Title X	Title V	Title XX	State Funds	Title X	Title V	Title XX	State Funds
United States Total	***47***	***29***	***8***	***33***	***28***	***15***	***5***	***26***
Alabama	✓	✓	✓	✓	✓	✓		✓
Alaska	✓	✓		✓				✓
Arizona	✓	✓			✓			
Arkansas	✓			✓	✓			
California	✓			✓				✓
Colorado	✓			✓	✓			✓
Connecticut	✓	✓	✓	✓				
Delaware	✓	✓		✓	✓	✓		✓
District of Columbia	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -
Florida	✓			✓	✓			✓
Georgia	✓			✓	✓			✓
Hawaii	✓	✓						
Idaho	✓				✓	✓		
Illinois	✓	✓	✓	✓	✓	✓	✓	✓
Indiana	✓	✓			✓			
Iowa	✓							
Kansas	✓							
Kentucky	✓	✓	✓	✓	✓	✓	✓	✓
Louisiana	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -
Maine	✓			✓				
Maryland	✓			✓				✓
Massachusetts	✓			✓				✓
Michigan	✓	✓		✓	✓			✓
Minnesota	✓			✓				✓
Mississippi	✓	✓		✓	✓	✓		✓
Missouri	✓	✓		✓	✓			
Montana	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -
Nebraska	✓							
Nevada	✓			✓	✓			
New Hampshire	✓	✓		✓	✓			✓
New Jersey	✓	✓	✓	✓	✓	✓	✓	✓
New Mexico	✓	✓		✓	✓	✓		✓
New York	✓	✓		✓	✓	✓		✓
North Carolina	✓	✓		✓	✓	✓	✓	✓
North Dakota	✓				✓			
Ohio	✓	✓		✓	✓	✓		✓
Oklahoma	✓			✓				✓
Oregon	✓	✓		✓				
Pennsylvania	✓	✓	✓	✓				
Rhode Island	✓							✓
South Carolina	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -
South Dakota	✓	✓			✓	✓		
Tennessee	✓	✓		✓	✓			✓
Texas	✓	✓	✓		✓	✓	✓	
Utah	✓	✓						
Vermont	✓		✓	✓				
Virginia	✓	✓		✓	✓	✓		✓
Washington	✓			✓				✓
West Virginia	✓	✓		✓	✓	✓		✓
Wisconsin	✓	✓						
Wyoming	✓	✓			✓			

Notes: - - - = States in which public health agencies did not respond to the survey.
* A check mark in this category represents coverage of any service in this category, including tubal ligation or vas
As of January 2000

Table A-3.

Public Health Coverage of Cancer Screening and Preconception Counseling

State	Cancer Screening				Preconception Counseling			
	Title X	Title V	Title XX	State Funds	Title X	Title V	Title XX	State Funds
United States Total	***46***	***27***	***9***	***32***	***41***	***25***	***4***	***27***
Alabama	✓	✓	✓	✓	✓	✓		✓
Alaska	✓	✓			✓	✓		
Arizona	✓	✓			✓	✓		
Arkansas	✓			✓				
California	✓			✓	✓			✓
Colorado	✓			✓	✓			✓
Connecticut	✓	✓	✓	✓				
Delaware	✓	✓		✓	✓	✓		✓
District of Columbia	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -
Florida	✓			✓	✓			✓
Georgia	✓			✓	✓			✓
Hawaii	✓	✓			✓	✓		
Idaho	✓	✓			✓	✓		
Illinois	✓	✓	✓	✓	✓	✓	✓	✓
Indiana	✓	✓			✓	✓		
Iowa	✓		✓		✓			
Kansas	✓				✓			
Kentucky	✓	✓	✓	✓	✓	✓	✓	✓
Louisiana	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -
Maine	✓			✓	✓			✓
Maryland	✓			✓	✓			✓
Massachusetts	✓			✓	✓			✓
Michigan	✓	✓		✓	✓			✓
Minnesota	✓			✓	✓			✓
Mississippi	✓	✓		✓	✓	✓		✓
Missouri	✓	✓		✓	✓	✓		✓
Montana	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -
Nebraska	✓			✓	✓			
Nevada	✓			✓	✓	✓		✓
New Hampshire	✓	✓		✓	✓	✓		✓
New Jersey	✓	✓	✓	✓				
New Mexico	✓	✓		✓	✓	✓		✓
New York	✓	✓		✓	✓	✓		✓
North Carolina	✓	✓		✓	✓	✓		✓
North Dakota	✓				✓			
Ohio	✓	✓		✓	✓	✓		✓
Oklahoma	✓				✓			✓
Oregon	✓	✓		✓	✓	✓		✓
Pennsylvania	✓	✓	✓	✓	✓	✓		
Rhode Island	✓					✓		
South Carolina	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -
South Dakota	✓	✓			✓	✓		✓
Tennessee	✓	✓		✓				
Texas	✓	✓	✓		✓	✓	✓	
Utah	✓	✓			✓	✓		
Vermont	✓		✓	✓	✓		✓	✓
Virginia				✓	✓	✓		✓
Washington	✓			✓	✓			✓
West Virginia	✓	✓		✓				
Wisconsin	✓	✓			✓	✓		
Wyoming	✓				✓			

Notes: - - - = States in which public health agencies did not respond to the survey.

As of January 2000

References

References

Alan Guttmacher Institute. *Issues in Brief: the Impact of Publicly Funded Family Planning. October, 1996*. Available at: www.agi-usa.org/pubs/ib8.html.

American Academy of Pediatrics. *Medicaid and S-CHIP Income Eligibility Guidelines for Children*. February 17, 2000. Available at www.aap.org/advocacy/eligibility.pdf.

Ellwood, Marilyn. *The Medicaid Eligibility Maze: Coverage Expands, but Enrollment Problems Persist.* Washington, DC: The Kaiser Commission on Medicaid and the Uninsured and The Urban Institute, September 1999.

Family Planning Councils of America, Inc. *Private Nonprofit Organizations and Family Planning Service Delivery*. www.fpcai.org/nonprof.htm.

Ferguson, C.C. and Leddy, T. The 'New Medicaid': An incremental path to national health care reform. *Family Planning Perspectives*, Vol. 31 (3), May/June 1999: 148–149.

Forrest J.D. and Samara, R. Impact of publicly funded contraceptive services on unintended pregnancies and implications for Medicaid expenditures. *Family Planning Perspectives*, 28: 188, 1996.

Gold, Rachel B. Implication for family planning of post-welfare reform insurance trends. *The Guttmacher Report*, December 1999: 6–9.

Gold, Rachel B. Key policies emerging to govern delivery of family planning in Medicaid managed care. *The Guttmacher Report*, February 1999: 3–4.

Gold, Rachel B. and Sonfield, Adam. Block grants are key sources of support for family planning. *The Guttmacher Report*, August 1999. Available at www.agi-usa.org/pubs/journals/gr020406.html.

Gold, Rachel B. and Sonfield, Adam. Family Planning Funding Through Four Federal-State Programs, FY 1997. *Family Planning Perspectives*, 31(4), 1999: 176–181.

Gold, R.B. State efforts to expand Medicaid-funded family planning show promise. *The Guttmacher Report on Public Policy*. April 1999: 8–11.

Health Care Financing Administration. *Medicaid State Operations Manual*, *Rev. 36, Sec. 4270.B.1*. Baltimore: Health Care Financing Administration, September 1988.

Health Care Financing Administration, Division of Financial Management, Office of Medicaid Management, Medicaid Bureau. Title XIX Financial Management Review Guide Number 20: Family Planning Services. Baltimore: HCFA, 1993.

Health Care Financing Administration, Center for Medicaid State Operations, HCFA-2082 Report, FY 1998. Available at www.hcfa.gov/medicaid.

Health Care Financing Administration. Letter to State Medicaid Directors on Revisions to the Hyde Amendment. February 12, 1998.

Health Care Financing Administration. Letter to State Medicaid Directors on Antidiscrimination, Anti-Gag Rule and Adequate Capacity Issues in the Balanced Budget Act of 1997. February 20, 1998.

Health Care Financing Administration. National Summary of Medicaid Managed Care Programs and Enrollment, June 30, 1998. www.hcfa.gov/medicaid/trend98.htm.

Health Care Financing Administration. Overview of the Medicaid Program, August 2, 1999. Available at www.hcfa.gov/medicaid/mover.htm. Accessed February 24, 2000.

Health Care Financing Administration. Medicaid Eligibility, February 22, 2000. Available at www.hcfa.gov/medicaid/meligib.htm. Accessed February 24, 2000.

The Henry J. Kaiser Family Foundation. *Issue Brief: State Policies on Access to Gynecological Care and Contraception*. Menlo Park, California: The Henry J. Kaiser Family Foundation, November 1999.

Kring, Thomas C. OPA Program Instruction Series, OPA 97-1: *Fees and Charges to Title X Low-Income Clients and Teenagers (revised)*, April 24, 1997. Available at www.hhs.gov/progorg/opa/titlex/xinstruc.html.

Office of Family Planning. *Title X Overview*. Available at www.hhs.gov/progorg/opa/titlex/ofp.html.

Planned Parenthood Federation of America, Inc. *America's Family Planning Program: Title X*, December, 1997. Available at www.plannedparenthood.org/Library/familyplanningissues/titlex.html.

Rosenbaum, Sara, Smith, Barbara M., and Shin, Peter, et al. *Negotiating the New Heath System: A Nationwide Study of Medicaid Managed Care Contracts, Second Edition.* Washington, DC: The George Washington University Center for Health Policy Research, February 1998.

Schlosberg, Claudia and Ferber, Joel. *Access to Medicaid Since the Personal Responsibility and Work Opportunity Reconciliation Act*. Washington, DC: National Health Law Program, January 1998.

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