Guttmacher Policy Review
Winter 2007 | Volume 10 | Number 1
GPR

Lessons for Family Planning Providers from Transitions In Maternal and Child Health Funding

By Rachel Benson Gold

By the end of 2006, the federal government had approved applications from 25 states to grant Medicaid coverage for family planning services to low-income women not poor enough for regular Medicaid eligibility. The income ceiling under most of these programs is at or close to 200% of the federal poverty line, well above the national average of 65% of poverty for regular Medicaid.

Together, these Medicaid eligibility expansions are beginning to change the face of how family planning services for low-income people are paid for in this country. Also, they move center stage the question of the appropriate future role for Title X family planning dollars in a system that one day may rely on Medicaid to fund direct health care services for most clients. While the family planning community is obviously just beginning to navigate this transition, maternal and child health (MCH) programs have been traveling this road for more than 20 years. Their experience is instructive.

Expanding Medicaid

The federal MCH program provides health care and related services to low-income children and pregnant women. Originally created in the 1930s, it remains the only federal-state effort that focuses solely on improving the health of mothers and children. MCH funds are distributed to states, which are required to spend at least 30% for preventive and primary care services to children and adolescents and at least 30% for services to children with special health care needs. Historically, states have viewed paying for services to pregnant and postpartum women as one of their core functions. As permitted by federal law, several states use their federal MCH and state matching funds to provide family planning services.

Like the federal Title X family planning program, the MCH program supports a diverse network of clinics, including local health departments, community health centers and other clinics operated by private, nonprofit agencies. And like Title X–supported clinics, those supported by the MCH program often cobble together funding from multiple sources to serve low-income women. Historically, MCH dollars were a lynchpin of these clinics' efforts to provide direct prenatal care to women; however, during the 1980s, Congress dramatically changed how publicly supported prenatal care is financed.

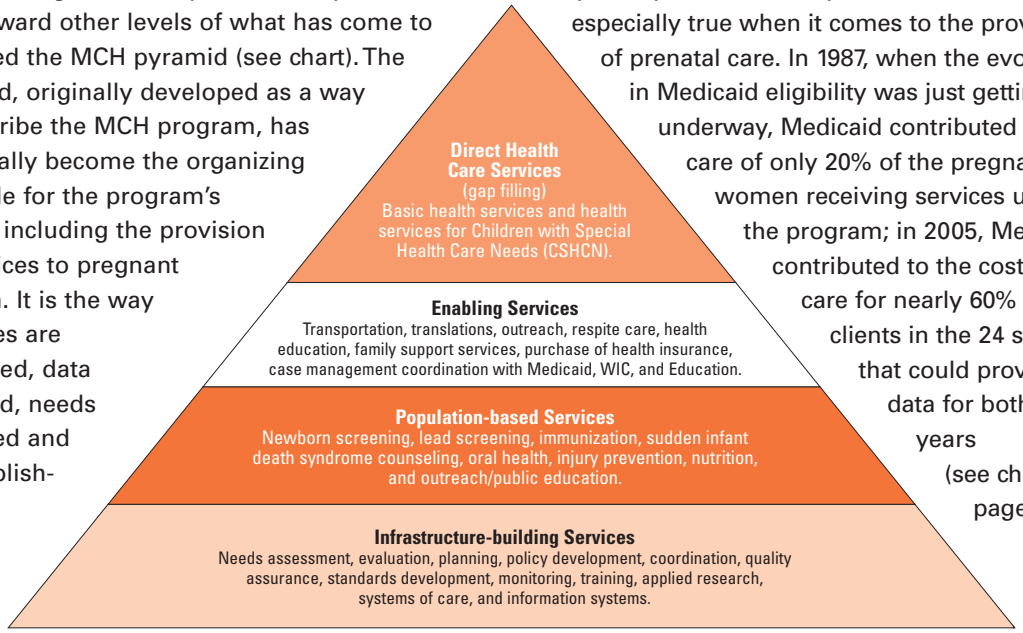
Through a series of incremental steps beginning in 1984, Congress expanded Medicaid eligibility for pregnancy-related services, a package that includes prenatal care, labor and delivery, and postpartum care. Before the expansions, these services were just like other Medicaid-covered care, and state-set eligibility levels averaged 56% of the federal poverty line. In 1989, Congress mandated that all states set the income-eligibility level at least at 133% of poverty, although states had the option to go even higher. Today, eligibility for pregnancy-related care averages 185% of poverty nationwide.

As Medicaid eligibility levels rose, so did the proportion of births covered under the program—from 15% of all births occurring in the United States in 1985 to nearly 40% today. The expansion of Medicaid as a way to pay for pregnancy-related

services freed up MCH funds previously used to pay for prenatal care, enabling the program to focus on other critical yet unaddressed needs.

The MCH Pyramid

With the dramatic expansion of Medicaid, emphasis within the MCH program shifted away from funding the direct provision of prenatal care toward other levels of what has come to be called the MCH pyramid (see chart). The pyramid, originally developed as a way to describe the MCH program, has essentially become the organizing principle for the program's efforts, including the provision of services to pregnant women. It is the way activities are described, data reported, needs assessed and accomplishments measured.



The MCH pyramid serves as the organizing principle for the program, with services for pregnant women falling into all four quadrants.

Peter C. van Dyck, associate administrator of the Maternal and Child Health Bureau (MCHB), the federal agency that oversees the program, readily acknowledges that the agency has tried to encourage states "to move toward the bottom of the pyramid" and focus on population-based services and infrastructure support as a way of maximizing the reach of the program. Unfortunately, there are no data looking specifically at expenditures for pregnant women. But, overall, about 60% of MCH program funding is spent on direct health care services, although much of that is likely to provide services to children with special health care needs for which other funding streams are limited. The distribution of program funds across the levels of the pyramid varies greatly from state to state.

Direct Health Care

Although there will always be a need to fund at least some direct service provision, it is telling that this quadrant of the pyramid is labeled by program officials as "gap filling," in recognition of their hope that the program will not be viewed as the funder of first resort, but rather as the "last-stop safety net," as van Dyck describes it. This is especially true when it comes to the provision of prenatal care. In 1987, when the evolution in Medicaid eligibility was just getting underway, Medicaid contributed to the care of only 20% of the pregnant women receiving services under the program; in 2005, Medicaid contributed to the cost of care for nearly 60% of clients in the 24 states that could provide data for both years (see chart, page 5).

Nationwide, nearly three in four pregnant women served by the MCH program have some source of third-party coverage, generally through Medicaid. Much of the direct health care services the program funds for pregnant women fills in gaps left by this third-party coverage. Often, this entails shouldering the cost of radiology, sonography, amniocentesis or other specialty care, especially for women with high-risk pregnancies who can need multiple and often expensive services. In yet another parallel to family planning, the MCH program is often looked to by providers to make up the gap between the cost of providing the care and the reimbursement paid by Medicaid.

Enabling Services

State programs fund a range of enabling services often missing from traditional insurance coverage. Depending on the needs of an individ-

ual client, these can include transportation, translation, care coordination, follow-up, group education, health education and child care. For example, Florida's MomCare program provides counseling, helps women access health care services, assists in follow-up of missed appointments and coordinates the range of different providers that may be involved.

Although enabling services can be important to the ability of low-income women to get into prenatal care early in pregnancy and to stay in care throughout the pregnancy, they are important to the delivery system as well, according to Bonnie Birkel, MCH director in Maryland. Providing services such as translation, child care and transportation can dramatically reduce the incidence of missed appointments, which cause ripples of inefficiencies throughout a clinic system.

Population-Based Services

Population-based services are the broadest of any of the MCH-funded activities, reaching the entire population of the state. States report a variety of public education efforts, from a public education campaign in West Virginia in conjunction with the local March of Dimes promoting early entry into prenatal care to a Florida campaign on the importance of taking folic acid prior to pregnancy to cross-disciplinary efforts in nearly all states aimed at identifying strategies to reduce infant mortality.

The federal statute authorizing the MCH program requires all state efforts to include a toll-free hotline that can refer women for needed services. Such programs vary from state to state. For example, an MCH hotline in Washington has grown into a more comprehensive effort known as WithinReach, which includes both a telephone hotline and a Web site. The effort provides access to basic health education materials in a variety of languages and information on where women can go for such services as prenatal care, WIC and food stamps. Hotline operators do a very basic eligibility screen and then refer callers to programs for which they may be eligible. Another example is Georgia's Powerline, which is looked to by program staff and other key MCH stakeholders as a way of identifying remaining unmet needs across the states, so that efforts can be made to address them.

Infrastructure Building

Under the rubric of infrastructure building, several states develop standards and guidelines for providing services, offer training and technical assistance to providers, and monitor service provision and outcomes. For example, in Maryland, a multidisciplinary advisory committee developed voluntary perinatal standards of care, which were incorporated into the regulations for hospitals statewide. This process has begun to allow for statewide data collection on specific indicators and interhospital collaboration for patient safety. More recently, the state has begun to pilot a telemedicine program in partnership with the University of Maryland. The program allows providers in rural areas to work in close consultation with specialists from the university, while allowing high-risk women to receive care without having to travel long distances.

Making the Transition

The 20-year transition of the MCH program abounds with lessons for family planning providers and advocates. Perhaps the most immediate lesson is that regardless of the extent to which Medicaid eligibility is increased, gaps will inevitably remain that will need to be filled by a flexible funding source—such as Title X in the case of family planning—that can adapt to changing conditions on the ground.

Moreover, even in an increasingly Medicaid-funded system, which permits an expanded provider base of private physicians, the dominant player in all likelihood will be the clinic network—which offers a stable cadre of professionals with expertise in serving vulnerable, special-needs populations. This remains the case for the clinics that had been major providers of subsidized pregnancy-related services, and it is already proving to be the case as a result of the expansion of Medicaid coverage for family planning in California. Private-sector providers such as physicians now comprise two-thirds of the providers in Family PACT—the state's Medicaid family planning expansion effort—but clinics still

serve nearly two-thirds of the clients.

An increased contribution from Medicaid, however, clearly can free up resources that could be used to provide more traditional public health services not covered under a per-patient reimbursement system, such as Medicaid or private insurance. By improving the quality of care for individual clients and buttressing the overall system, these activities—currently well beyond the reach of cash-strapped family planning providers and programs—yield important public health benefits. In fact, according to MCH program staff in Georgia, "if we're ever going to get to good public health in our state, it will have to be through the bottom of the pyramid."

Clearly, the specific "bottom-of-the-pyramid" services offered in a family planning program would differ from those offered in an MCH program. In fact, the same types of basic public health services provided by state MCH programs are already being adapted to a family planning context in places. For example, Washington's MCH hotline provides basic education about birth control and information on how to access subsidized family planning services. Moreover, the initial phases of the state's Medicaid family planning expansion included an intensive follow-up component for some clients. Intensive follow-up to women who have obtained care is often an important aspect of the enabling services provided by state MCH programs.

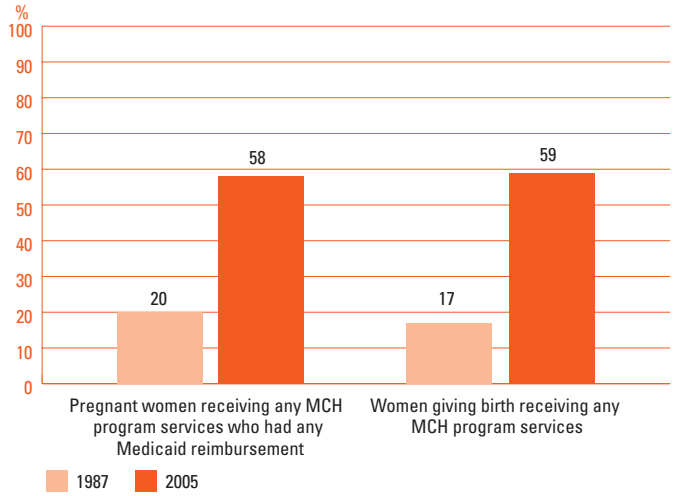
Pitfalls and Promise

All of this, however, is not to say that the transition within the MCH effort has been a uniformly easy one, devoid of difficulties and rough spots. First and foremost, financial pressures on relatively scarce MCH dollars are intensifying even as appropriations for the program have leveled off. (Although the MCH program had received consistent annual increases before 2002, this has not been the case since.) The exclusion from Medicaid of immigrants—both recent legal immigrants and those who are undocumented—has been a significant contributor to the pressure, which has been felt by family planning providers as well (related article, page 7). Cassie Lauver, director of state and community health at the federal MCHB, worries that the need of some state programs to use federal MCH dollars to provide care to immigrants threatens to reverse the current trend, which has been to move away from using MCH dollars to fund direct services. Florida's MCH staff, according to Director Annette Phelps, has found that the gap between funded and unfunded prenatal care is widening and a marked increase in noncitizen births is straining the ability of safety-net providers to offer needed services. Although the focus of the past decade on care coordination, outreach and education continues, more attention is being required to assure the provision of basic prenatal care.

Second, according to Holly Grason of the Johns Hopkins University, the very flexibility of MCH dollars has to some extent proven to be a mixed blessing. In yet another parallel that has clear lessons for Title X, the MCH program is sufficiently nimble to adapt to local conditions and needs. Funds can be allocated to provide direct care for individuals ineligible for Medicaid. Moreover, state MCH funds can help support clinic operations in the face of the chronic failure of Medicaid reimbursement to cover the full cost of care provided in clinics. At the same time, this very decentralization can make articulating a

A CHANGING ROLE

Both the importance of Medicaid and the reach of the MCH program have grown over time.



Note: Data are for 24 states with comparable data for both variables and both years.
Sources: Guttmacher Institute tabulations of data from Association of Maternal and Child Health Programs, 1989, and Maternal and Child Health Bureau, 2007.

coherent rationale for the program at a national level a significant challenge.

MCH officials at both the federal and state levels are still grappling with how to describe the program to policymakers in compelling ways. In fact, the transition to a Medicaid-based system has enabled the program to extend its reach to a greater segment of the population. In 1987, when only a fifth of the pregnant women served with MCH funding were eligible for Medicaid, the program was able to provide services to only 17% of the women giving birth in those states. But by transitioning to a broader-based effort focusing on public health and population-based services, state programs were able to provide at least some services to nearly six in 10 women giving birth in 2005 (see chart, page 5). That said, program officials and supporters continue to lament the difficulty of advocating for a program where accomplishments and impact cannot be neatly—and dramatically—measured by adverse outcomes averted.

In short, the 20-year transition in the MCH program has not been a proverbial walk in the park, but it has resulted in an effort that essentially compliments rather than duplicates Medicaid, filling in the sometimes considerable gaps in eligibility, services and funding left by even that massive program. Although the program has not at all abandoned its mission of caring for pregnant women, it has shifted from an emphasis on funding direct care to one of providing broader-based public health services. Throughout it all, the front-line clinics remain critical as health care providers, albeit with a different mix of funding streams.

For family planning providers, the transitions experienced by MCH programs are likely to accelerate, as more states move to expand Medicaid family planning eligibility. Acceleration could take a quantum leap forward if Congress adopts a nationwide expansion (related article, Summer 2006, page 2). The lesson of the MCH experience is that making these transitions is a challenge, albeit not an insurmountable one. Although funding streams may change, the network of community-based clinics will remain the vital safety net. And, with the creativity and ingenuity that have long been a hallmark of the family planning provider community, the nimbleness of Title X dollars can be harnessed to fill in the gaps that will inevitably remain, no matter how high Medicaid eligibility levels are raised. As the need to help young and disadvantaged women avoid unintended pregnancy will remain, so will the need for programs and providers to play this critical public health role.

www.guttmacher.org

This article was supported by grants from The California Wellness Foundation (TCWF) and the Compton Foundation for the Guttmacher Institute's initiative, "Transitions in U.S. Family Planning Financing: Implications and Opportunities." The conclusions and opinions expressed in this article, however, are those of the author and the Guttmacher Institute.