

## Stronger Together: Medicaid, Title X Bring Different Strengths to Family Planning Effort

By Rachel Benson Gold

Once a rarity, state initiatives to expand eligibility for family planning services under their Medicaid programs are now increasingly commonplace. Half of all states have received permission from the federal government to waive the normal eligibility rules under Medicaid to initiate such programs, and several of these programs have been in operation for many years. The resulting increase in Medicaid dollars for subsidized family planning services has begun to allow providers to leverage the different but clearly complementary strengths of Medicaid and Title X, while quietly crafting a comprehensive and multifaceted effort aimed at some of the individuals in need of publicly funded family planning who are most difficult to reach and serve.

This is the second in a two-part investigation into the ways the Medicaid eligibility expansions are changing how family planning services for low-income individuals are financed in the United States, and the optimal role for Title X in a system under which service providers may be able to rely on Medicaid to fund at least the most basic package of health care for most of their clients. The first looked at lessons learned from a similar, although considerably more established, transition in maternal and child health financing and service delivery (related article, Winter 2007, page 2).

This article is based on discussions with staff from Title X grantees in several states with Medicaid waivers: Arkansas, Oregon, South Carolina and Wisconsin. In addition, the article was greatly informed by a site-visit to the primary Title X grantee and two of its delegate-agency clinics in

California—a state whose Medicaid family planning expansion serves twice as many clients as all the other state expansions combined.

### Getting Noticed

Since 1993, 25 states have instituted some form of program, known as a Medicaid “waiver,” to expand eligibility for family planning to certain individuals in the state who do not meet the state’s regular Medicaid eligibility requirements. Of those, 18 have the broadest type of program, in which eligibility is based solely on income (see map). With the recent federal approval of proposals from Texas and Illinois, seven in 10 women in need of publicly subsidized family planning in the United States live in a state with a Medicaid family planning eligibility expansion.\*

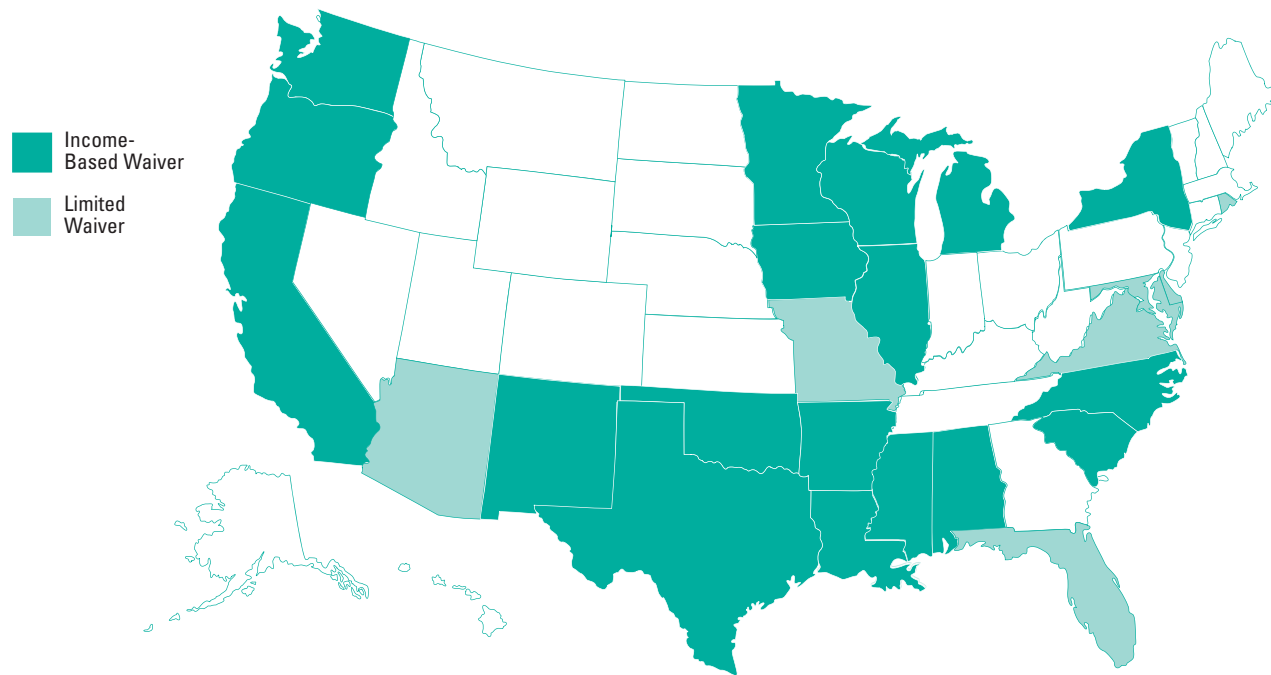
Research on the impact of these efforts is accumulating. Guttmacher Institute data from 2001 demonstrated that states with income-based expansions spend more per capita on family planning and are able to meet more of the need for services, compared with other states (see chart). Most recently, a 2007 article by researchers from the Medical University of South Carolina published in *Women’s Health Issues* found that Medicaid family planning expansions result in lower birthrates, with the broad, income-based programs having the greatest impact.

By providing contraceptive services to women who would become eligible for Medicaid if they experienced an unintended pregnancy, family

\*Women are considered to be in need of publicly subsidized family planning if they are of reproductive age, sexually active, able to become pregnant but not wanting to be and, if 20 or older, in a family with an income below 250% of the federal poverty level.

## FAMILY PLANNING EXPANSIONS

As of April 2007, the federal government has approved Medicaid family planning expansion programs in 25 states—most often open to women based solely on their income.



*Note:* Income-based waiver refers to states with expansions for women (and sometimes men) with family incomes up to a specified level, most often at or near 200% of the federal poverty level. Limited waiver refers to states with expansions only for women who have left Medicaid either following a Medicaid-funded delivery or (in Delaware) for any reason.

planning waiver programs generate substantial cost savings. A 2003 federally funded evaluation of programs in six states found that all yielded significant savings to both the federal government and the states. Although savings can be generated by several different approaches to expanding Medicaid eligibility, Guttmacher Institute researchers have determined that the most cost-effective approach is to establish parity between the income ceiling a state uses to determine eligibility for Medicaid-funded pregnancy-related care and the state's income ceiling for family planning. In 2006, they concluded that this approach, if instituted nationwide, would save \$1.5 billion in federal and state dollars annually by the third year, while reducing unintended pregnancy and abortion rates in the United States by 15% (related article, Summer 2006, page 2).

### Leveraging Differences

Gradually, the macro-level benefits of the Medicaid family planning eligibility expansions are being recognized and acknowledged. Less

visible, however, are important changes occurring to programs on the ground. In state after state, the influx of Medicaid dollars into cash-strapped family planning programs has enabled Title X grantees and the service providers they fund to begin to develop multifaceted efforts leveraging the very different strengths of Medicaid and Title X.

Essentially, Medicaid is an insurance mechanism that reimburses health care providers for a discrete set of services that are provided to individuals who meet the program's eligibility requirements. Even at its most expansive, however, the program is likely to pay for only the core services that are needed to promote effective contraceptive use, and only for those individuals determined to be eligible. At the same time, the program is noteworthy as a financing mechanism for family planning in that funding is open-ended, allowing it to grow as need expands. Currently, Medicaid supplies just over six in 10 public dollars for family planning services in the United States.

In sharp contrast to Medicaid, funding for Title X is dependent less on need than on political will—something that has been sorely lacking in recent years. Funding for Title X is 61% lower today than it was in 1980, when inflation is taken into account. As a result, Title X supplies far fewer public family planning dollars than does Medicaid, but the program—and other similar funding sources for family planning, including the maternal and child health and social services block grants as well as dedicated state revenues—brings other critical strengths to the table. Title X funds can serve individuals not eligible for Medicaid, and—because Title X is a grant program under which funds are distributed to grantees who design and operate their own programs—funding can be targeted to local needs and challenges. Unlike Medicaid, for example, Title X can subsidize the intensive outreach necessary to encourage some individuals to seek services. Furthermore, by paying for everything from staff salaries to utility bills to medical supplies, Title X funds provide the essential infrastructure support that enables clinics to go on and claim Medicaid reimbursement for the clients they serve.

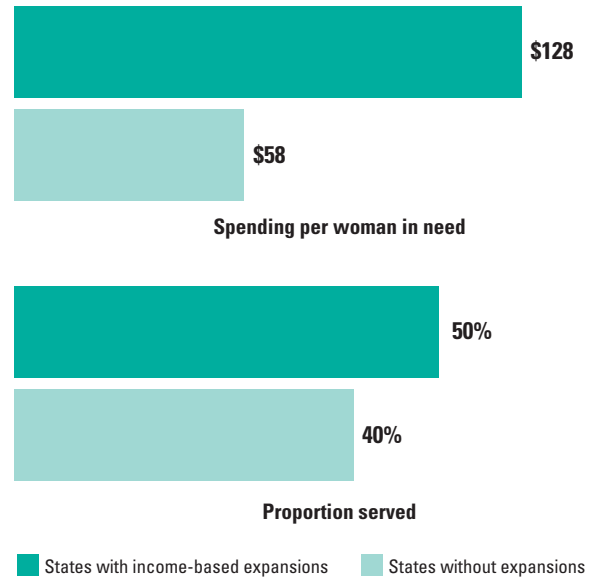
In some states with family planning waivers, the emerging synergy between these two very different programs is beginning to yield something approaching a comprehensive effort to reach and serve some of the hardest to reach and serve populations in need. Medicaid is at the core of this effort, providing a basic set of clinical services for those who are eligible. But Title X wraps around that core to provide the infrastructure, staff and full package of services for enrollees. It funds the outreach activities necessary to meet the unmet need. Finally, and of critical importance, Title X remains the provider of last resort for those ineligible for Medicaid despite the eligibility expansions.

### Infrastructure

In many cases, the Medicaid expansions have enabled Title X grantees to target long-simmering infrastructure issues. “Before the waiver, we had a second-tier infrastructure, with a physical plant that limited our client capacity,” according to Jim Stewart, president and CEO of Planned

## EFFECTIVE EXPANSIONS

States with income-based Medicaid family planning expansions outshine states without expansions in their funding of contraceptive services and the proportion of women in need of subsidized care served at publicly funded clinics.



Parenthood of Wisconsin, the Title X grantee in the state. With approval from the Office of Population Affairs, the federal agency that administers Title X, the grantee was able to relocate and expand the program’s largest clinic, which is located in a large and growing Hispanic community. The new site was configured to serve many more clients and to have extended operating hours. As a result, a clinic that had been open for a regular 40-hour week is now available to serve clients for 12 hours a day on weekdays and nine hours on Saturday—a critical change in a low-income community where residents often have little flexibility to leave work to obtain medical care.

Nontraditional hours are essential to reach the “invisible” people, such as women who are homeless or those who work as domestics or in sweatshops, notes Deb Farmer, CEO of the Westside Family Clinic, a small Title X–supported clinic in Los Angeles. “Where do you go for health care,” she asks, “if you’re only off from work on Sunday afternoons?” Another Title X–supported clinic in the California system, the Eisner Pediatric and Family Medical Center, not only provides extended hours on a regular basis, but stays open on all holidays, except Christmas.

But infrastructure needs extend beyond physical space to the supplies clinics need to operate. Bradley Planey, state family planning administrator in Arkansas, uses Title X funds to centralize the purchasing of supplies for local health department clinics. As a result, everything from paper gowns to contraceptives is purchased in bulk at the state level and distributed to local clinics as needed. Although this requires a significant initial outlay, which up-front money under the state's Title X grant makes possible, the final cost is less than if the purchasing were done locally.

### Staffing

Staff training is an ongoing issue because the low salaries in public clinics lead to high turnover rates, especially among nurses and nurse practitioners. Janet Sheridan, who administers the Title X grant to the state of South Carolina, notes that prior to a recent infusion of state dollars, "a nurse could work only two 12-hour shifts a week at a hospital and make what would be a full-time salary at a health department clinic."

Feeling the same ongoing need, several programs in waiver states are devoting significant Title X dollars to training. The California Family Health Council (CFHC), which is the primary Title X grantee in California, has placed a special emphasis on supporting a comprehensive training effort to help meet the diversity of local programs' staffing needs and ensure that the quality standards of the Title X program are maintained. According to Maryjane Puffer, director of clinical and community health programs, clinical conferences train 400 clinicians (mostly nurse practitioners) a year. While providing the necessary continuing medical education to existing staff, the conferences offer new staff training specifically targeted to offering family planning to clients in public health programs, an emphasis not found elsewhere. Through a separate internship program, CFHC places masters-level students in Title X clinics, as a way of training the next generation of clinic administrators, managers and evaluators.

Finally, a third CFHC program trains community health workers, the front-line staff clinics rely on to make appointments, conduct patient intake,

provide basic education and counseling, and serve as patient advocates who can shepherd clients through the visit. In a state grappling with a multiplicity of language issues, community health workers play a particularly critical role. According to Farmer at the Westside clinic, where 35 of the clinic's 45 staff members are bilingual community health workers, clients do not want to go through a translator; they want to hear information directly. Having trained community health workers, according to Farmer, is critical to the clinic's ability to obtain meaningful informed consent, especially in a population leery that interaction with the health care system may result in questions about their immigration status.

### Gaps in Covered Services

In general, Medicaid will provide the basic package of services routinely provided in the course of a family planning visit. Although the details differ from state to state, this usually includes client counseling and education, contraceptive drugs and devices, and related diagnostic tests, such as testing for cervical cancer, pregnancy and STIs.

But for some Medicaid enrollees, that package is not sufficient to meet the nationwide Title X standards for the delivery of high-quality family planning services to individuals in need of publicly subsidized care. Title X funds are critical to bridging the gap between that basic package and the Title X quality-of-care standards. For example, some clinics in Oregon use Title X funds to cover STI treatment for family planning clients, a service not covered under the Medicaid waiver in that state, as well as in others. Title X funds are also used in Oregon to cover repeat Pap tests needed by clients served under the waiver program.

Similarly, the Medicaid waiver in Wisconsin does not cover HIV testing. The Title X guidelines, however, require HIV testing for any high-risk client served at a Title X-funded clinic. As a result, Title X is often called upon to shoulder the cost of HIV testing for enrollees in the Medicaid waiver program.

### Counseling

As is the case with clinical care, Medicaid waiver programs will pay only for the routine counsel-

ing that is provided as part of a standard family planning visit. For example, in California, according to Carmen Ibarra, director of clinic operations at the Venice Family Clinic, a Title X–funded site in the Los Angeles area, a client receives an average of about 10 minutes of counseling in the course of a routine, initial family planning visit. A homeless client or a teenager can easily take twice as long. Homeless clients, Ibarra adds, often need to talk about the many intersecting issues in their lives, and are likely to have more mental health concerns. For teens, the issue is one of maturity level, and a frequent need to counterbalance the bad information from peers. Family PACT, the state’s Medicaid waiver program, however, covers only the counseling routinely provided to clients.

The Venice clinic uses Title X–funded case managers to fill in at least part of the gap. The case manager reviews the information provided by the clinician and makes sure all the client’s questions have been fully answered, sometimes calling the physician back to spend more time with the client, if necessary. Case managers encourage clients to call with follow-up questions or issues that arise after the visit; in addition, they schedule appointments and follow up on missed appointments.

Teenagers calling the Venice clinic are given the opportunity to attend a special teen clinic, one of several across the state supported in part with Title X funds. At these sites, peer educators try to provide the patient advocacy on the front end that the case managers offer on the back end, according to Ibarra. They start conversations in the waiting room in hopes of both providing basic patient education and putting clients at ease. Peer counselors stay with a client throughout the visit if requested, often for a client’s first Pap test or family planning visit. Although the visit itself may be reimbursed through Family PACT, the peer educator is funded with Title X dollars—and often has been through the Title X–funded community health worker training program.

### Outreach and Education

Although they may phrase it differently, Title X grantees in states with Medicaid family planning

waivers all say that meeting the unmet need for publicly subsidized family planning is first and foremost an outreach challenge. Although Medicaid will pay for basic outreach efforts as part of overall administrative expenses, the intensive outreach required to reach special populations often falls to Title X. South Carolina, for example, is launching its first-ever large-scale outreach effort this year, funded in part by Title X. The effort will involve posters, brochures, TV and radio spots, and a toll-free hotline.

Outreach activities are stressed by other grantees as well. Ibarra of California’s Venice clinic says her agency sends street outreach teams into the community with backpacks of condoms and basic educational materials, while other teams make regular visits to homeless shelters. Often, it will take multiple visits to a shelter or street-corner conversations until someone feels safe enough to come to a clinic. According to Ibarra, Title X will fund and train the outreach workers, purchase the condoms and often even develop the educational materials they distribute. Only when a client actually comes to the clinic is reimbursement available (through Medicaid or any other source), and then only if the client qualifies. According to Annette Amey, director of program evaluation for CFHC, “it’s all about getting people to the inside of the clinic door, and for that Title X dollars are indispensable.”

Planned Parenthood of Wisconsin conducts an outreach program aimed at helping Latina parents communicate with teens about sexual and reproductive health issues. According to Maria Barker, multicultural programs manager at Planned Parenthood, “It’s about building a relationship with the community, showing them we are a community-based organization that they can feel comfortable coming to. I don’t expect the clients to come to me; I need go to them.” As part of Barker’s effort, the staff conduct home health parties to talk about parent-child communication, STIs, contraceptive methods and available services. Barker has found that people are more willing to talk sitting around the kitchen table than in a more formal setting. “It’s a good way to get them comfortable with coming into the clinic for services.”

Currently, the agency funds the program with private revenues. But, according to Planned Parenthood's Stewart, this kind of effort is a perfect fit for Title X. "This program is an effective way to reach out to the community and identify those people who need our services."

### Payer of Last Resort

At the end of the day, a basic role for Title X has always been—and will always be, regardless of changes to Medicaid eligibility—the direct provision of family planning services and supplies to those in need who are unable to pay. "Without Title X," stresses Planey in Arkansas, "we would only be able to see the relatively few people who come to us with some type of coverage or who could pay themselves." And, indeed, even though some states have dramatically expanded Medicaid eligibility for family planning, none of these expansions cover individuals with an income up to 250% of poverty, the ceiling for receiving subsidized services under Title X.

Those ineligible for Medicaid are increasingly immigrants—either those in the country illegally who are ineligible for anything other than emergency services or recent legal immigrants who are barred from coverage for their first five years of residency—and citizens unable to meet the new documentation requirements for enrollment (related article, Winter 2007, page 7). South Carolina's Sheridan says almost the entire clientele of several health department clinics in the state is ineligible for Medicaid because of immigration status. In Oregon, enrollment in the state's family planning waiver has dropped since the implementation of the citizenship documentation requirement, according to Rian Frachele, administrator of the state's family planning program, increasing the draw on scarce Title X dollars.

### Emerging Synergy

The Medicaid family planning eligibility expansions have unleashed tremendous creativity in family planning efforts. In California, a state with a large-scale and long-established effort, providers finally have the resources to begin to tackle some of their most intractable service-provision challenges: to reach out to the hardest to

reach populations and effectively serve them once they come in for services. This raises the possibility of the nation's family planning effort one day truly being able to meet the remaining unmet need for subsidized services.

Legislation pending in both houses of Congress would transform what has been a state-by-state effort into a national one. By expanding Medicaid eligibility for family planning throughout the country, national Title X policy also would be brought into play, in much the same way as the Medicaid expansions for pregnancy-related services engaged maternal and child health policy on the national level. Such a move would formalize the work now being done by and within the states to design a comprehensive effort that builds on the complimentary strengths of Medicaid and Title X.

But one thing is already abundantly clear: Although Medicaid can bring a critical influx of new public dollars to family planning programs, Title X is indispensable in wrapping around Medicaid to reach out to individuals in need of services; to maintain the very existence of the providers needed to serve those individuals; and to offer the full range of services necessary to support effective contraceptive use among clients who need more than the basic package covered under Medicaid. In short, the Medicaid family planning expansions make Title X all the more critical as a central component in an overall strategy to support the comprehensive contraceptive services necessary to enable the nation's young and low-income women to avoid unintended pregnancy. [www.guttmacher.org](http://www.guttmacher.org)

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